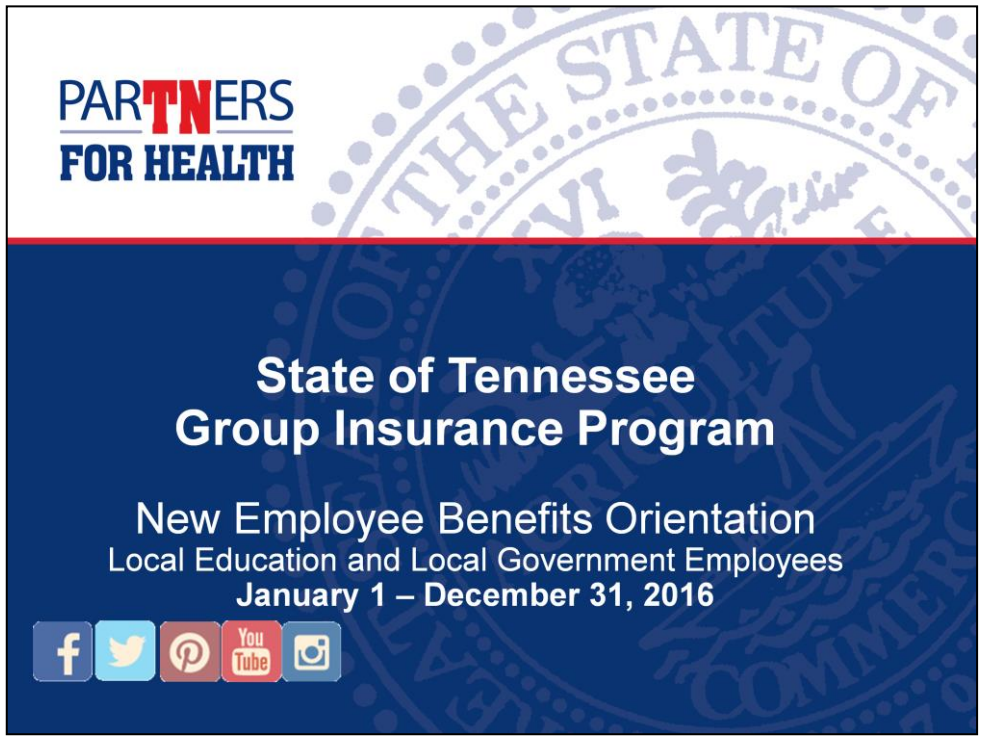
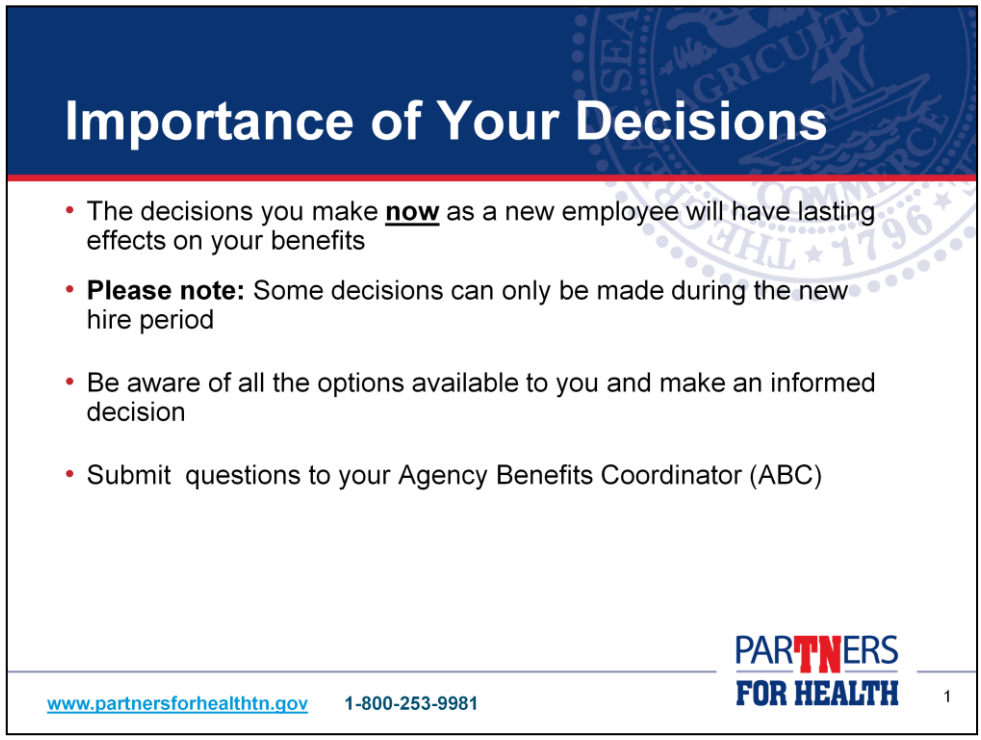
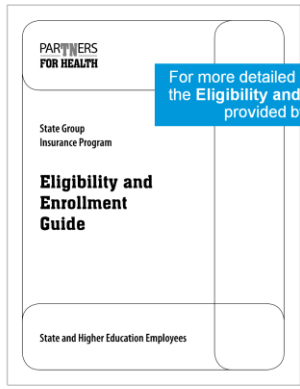


- Welcome to the State of Tennessee Group Insurance Program New Employee Benefits Orientation for Local Education and Local Government employees. This presentation will provide an overview of the benefits available to you as a new employee.
- The presentation will run through all of the slides without stopping. However, if you would like to hear a section again, you may pause and rewind at any time. You may also use the tabs on the right side of your screen to review by section.

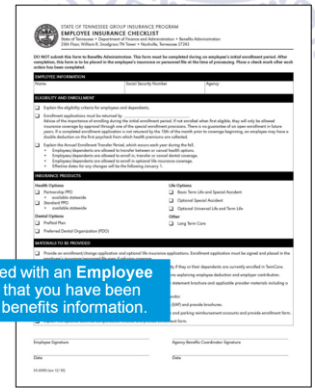


- The State provides a comprehensive benefits package for you and your eligible dependents. It includes health, dental, vision and long-term care insurance and other financial and counseling benefits.
- You have many options. Some of the benefits explained in this presentation are only available during the new hire period. Your Agency Benefits Coordinator (ABC) can tell you how long your new hire period lasts.
- If you have questions after the presentation, please make sure to follow up with your ABC.

Resource Materials



For more detailed information, refer to the **Eligibility and Enrollment Guide** provided by your ABC.



You will also be provided with an **Employee Checklist** to confirm that you have been informed of important benefits information.

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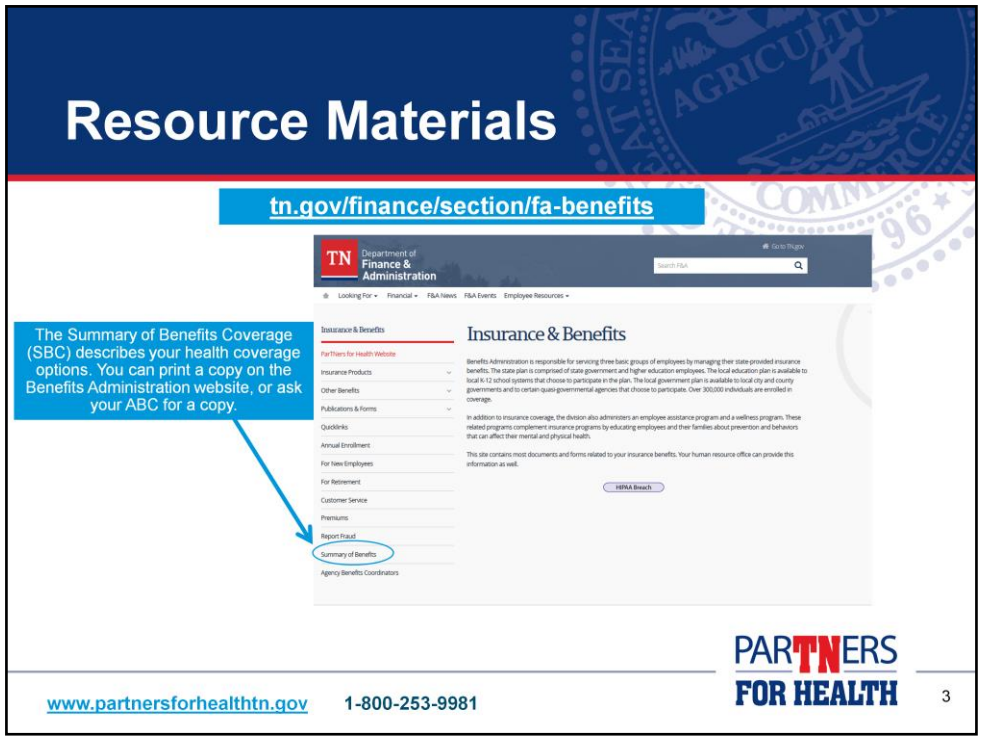
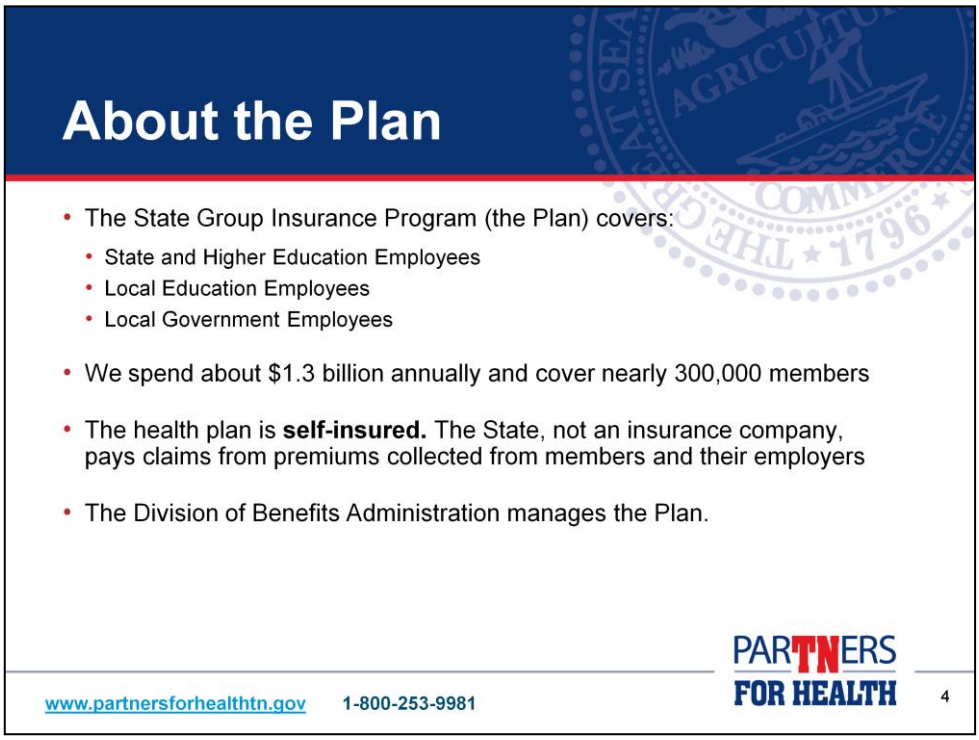
- More detailed information about the topics in this presentation can be found in the Eligibility and Enrollment Guide on the Benefits Administration website (**tn.gov/finance/section/fa-benefits**) under the "**Publications**" page.
- Your ABC will provide you with an employee checklist to confirm that you have received this important benefit information. After the presentation, please sign the checklist and return it to your ABC.



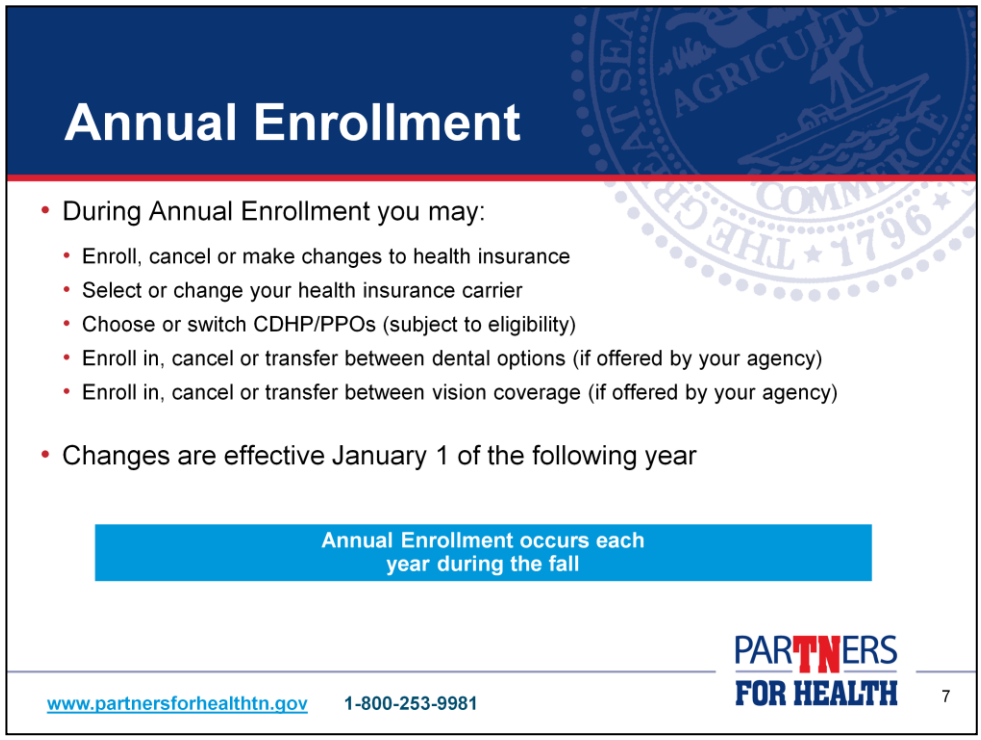
- As required by law, the State of Tennessee Group Health Program has created a Summary of Benefits and Coverage (SBC for short). It describes your health coverage options.
- You can read and print it from the main page of the Benefits Administration website at **tn.gov/finance/section/fa-benefits** by clicking on Summary of Benefits. You may also request a free printed copy from your ABC.
- Most information found in the SBC is covered in more detail in other publications like the Eligibility and Enrollment Guide, Plan Document and Member Handbooks. These can be found under the "**Publications**" tab on the same website.



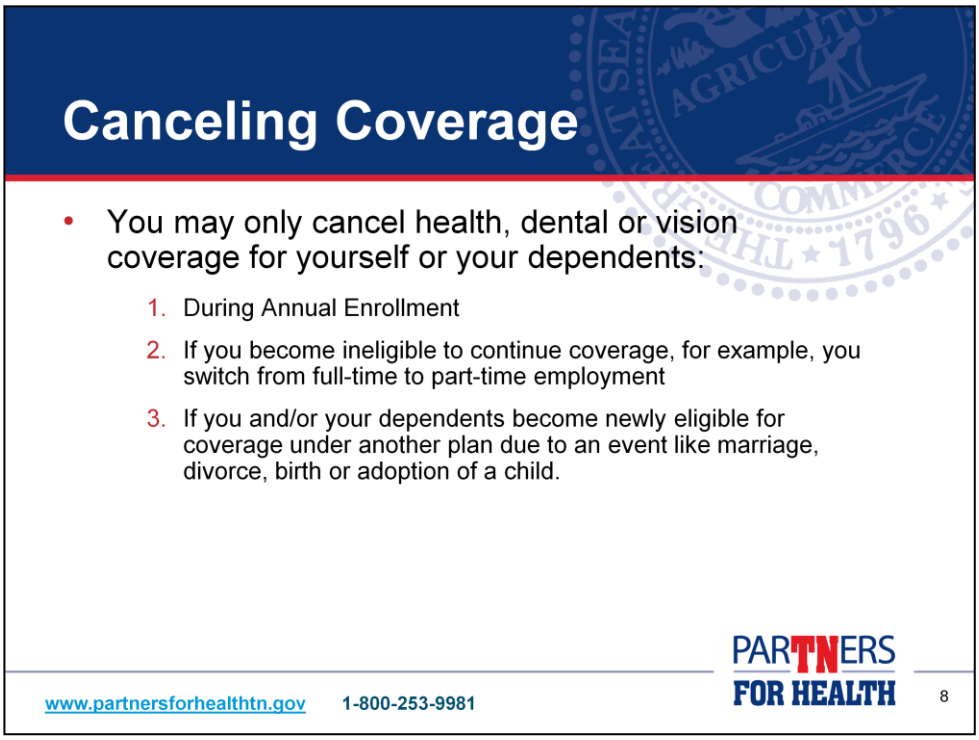
- The State of Tennessee Group Insurance Program covers three groups:
  - The State Plan for State and Higher Education employees
  - The Local Education Plan for K-12 teachers and support staff and
  - The Local Government Plan for employees of quasi-governmental agencies and municipalities
- We spend about $1.3 billion annually in claims costs for our nearly 300,000 members.
- The Plan is self-insured. All claims are paid through the combined premiums of our members and any contributions that your employer makes toward your monthly premium. The State is the plan administrator rather than an insurance company. The State contracts with insurance carriers to manage the Plan's provider networks, provide member services and manage claims payments on behalf of the State.
- Benefits Administration manages the Plan and works with your ABC to communicate program information. Your ABC will help you with any benefits-related questions or concerns you may have.

- Full-time employees are eligible for benefits. For insurance purposes, a full-time employee is defined as someone regularly scheduled to work no less than 30 hours per week in a non-seasonal, non-temporary position.
- If you have a family, you may choose to also cover your eligible dependents. A dependent can be a legally married spouse or a child up to age 26. To be considered an eligible dependent, children must be natural, adopted or step-children or children for whom you are the legal guardian.
- If you have a disabled child, you may be able to continue coverage for your child after age 26. For more information refer to the Eligibility and Enrollment Guide or consult your ABC.
- If you are currently enrolled in TennCare, you must inform your caseworker at TennCare of your new employment within 10 days of your hire date. You must report your new job, salary and that you have access to medical insurance with your new employer.
- If you have a dependent child on another plan including TennCare, the child can be carried on another plan.

- There are only three times when you may add health coverage:
  - The first is right now, when you are a new employee
  - The second is during Annual Enrollment in the fall
  - And the third is if you experience a special qualifying event during the year such as marriage, the birth of a baby or a spouse losing their coverage. If you do not select coverage now, but you later experience a special qualifying event, you must submit paperwork within 60 days of the event to add coverage. For a complete list of special qualifying events contact your ABC.

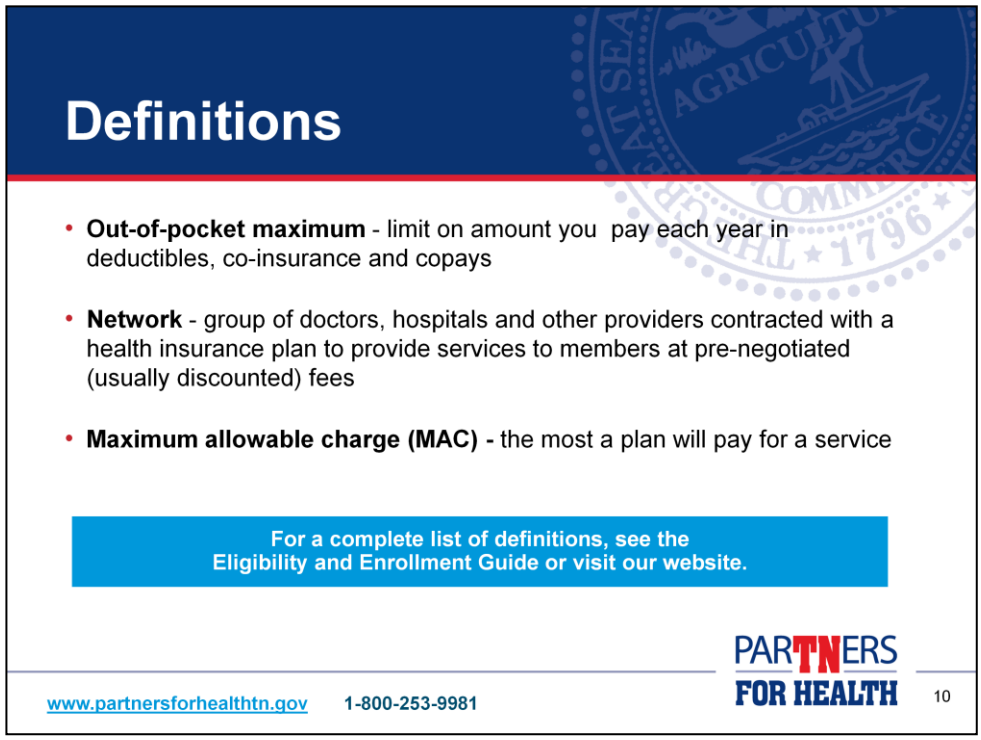


- An Annual Enrollment period is held each fall for most programs.
- You can choose health insurance options:
  - Enroll in or cancel health insurance for yourself or your eligible dependents
  - Choose or switch your plan type
  - Select or change your health insurance carrier (BlueCross BlueShield or Cigna)
- If offered by your agency, enroll in, cancel or transfer between dental options (Cigna or MetLife).
- Enroll in, cancel or transfer between vision coverage, again if offered by your agency (EyeMed Basic or Expanded).
- If you don't enroll in health insurance as a new employee, you will have the option to enroll during the fall Annual Enrollment for coverage effective Jan 1 the following year.



- There are three times that you can cancel your health, dental or vision coverage later:
  - During Annual Enrollment.
  - If you become ineligible to continue coverage. For example, this could occur if you switch from full-time to part-time employment.
  - Or if you experience one of the qualifying events listed on the Insurance Cancel Request Application.
- It's important to remember that, outside of Annual Enrollment, you cannot cancel coverage at any other time during the plan year unless you experience one of the approved qualifying events or you become ineligible to continue coverage.

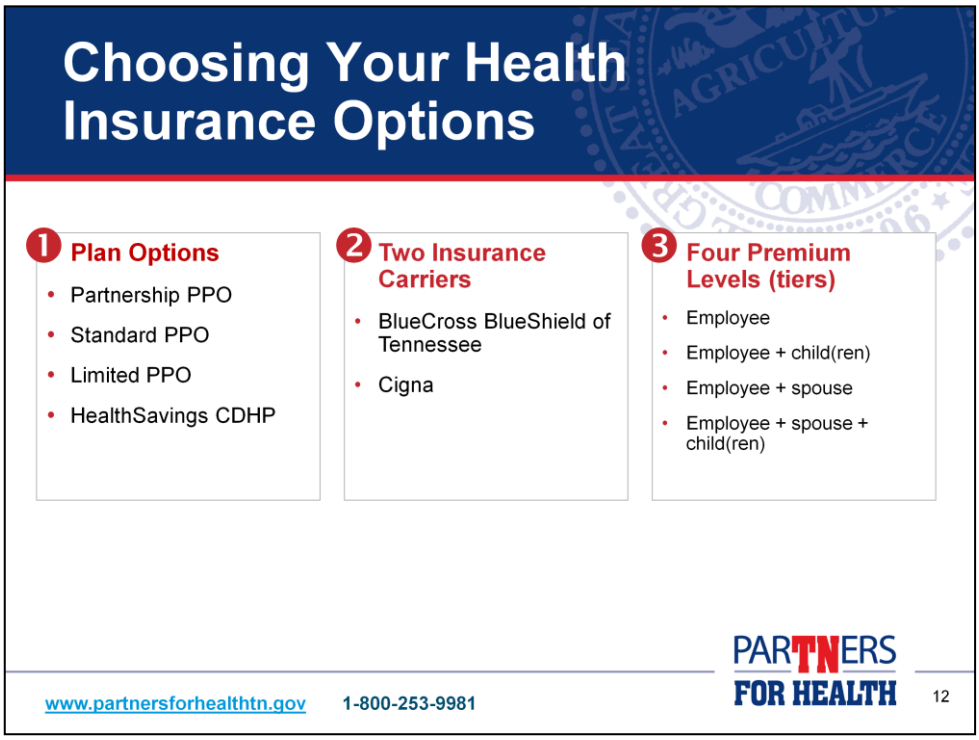
- Let's review some of the terms we use frequently to discuss insurance benefits.
- **Premiums** are the amount you pay each month for your coverage regardless of whether or not you receive health services. Your premium will be deducted from your paycheck automatically. Ask your ABC how your agency handles monthly premiums to be sure.
- A **copay** is a flat dollar amount you pay for services and products, like office visits and prescriptions.
- A **deductible** is a set dollar amount that you pay out-of-pocket each year for services. It's important to note that there are separate deductibles for in-network and out-of-network services.
- **Coinsurance** is a form of payment where you pay a percentage of the cost for a service after meeting your deductible.



- The limit to the amount of money you are responsible for paying each year in deductibles, co-insurance and copays is called the **out-of-pocket maximum**. Once you reach your medical out-of-pocket maximum, the plan pays eligible expenses for the rest of the year and you won't have to pay any more out-of-pocket. This does not apply to premiums. There are also separate out-of-pocket maximums for in-network and out-of-network services. **Please note:** There is a separate pharmacy out-of-pocket maximum for the PPO plans but pharmacy is included in the CDHP out-of-pocket maximum.
- A **network** is a group of doctors, hospitals and other providers contracted with a health insurance plan to provide services to plan members at pre-negotiated fees. Because the insurance company has not negotiated a lower price with out-of-network providers, you will pay higher amounts for services from those providers.
- All services have a **maximum allowable charge or MAC**. This is the most that a plan will pay for a service. When you visit an in-network provider, you don't have to worry about exceeding the MAC. In-network providers agree in advance to fees that don't exceed the maximum. If you see an out-of-network provider who charges more than the MAC for non-emergency services, you will pay the additional amount due.
- To view a complete list of terms and definitions, see the Eligibility and Enrollment Guide or visit the ParTNers for Health website.

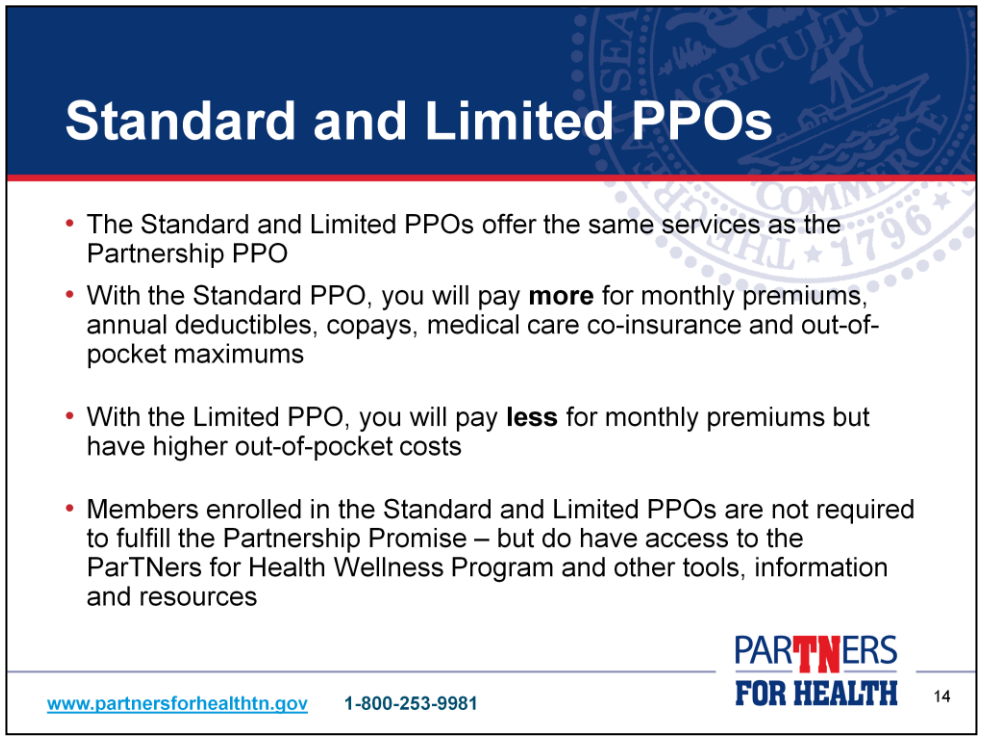
- We also have ALEX!
- ALEX is the new tool that explains your benefits choices and may help you choose which plan is best for you. Alex will be available online 24/7.
- Go to www.partnersforhealthtn.gov and **click on ALEX for Local Education and Local Government**. This tool will walk you through your health plan options and estimated costs based on information you enter into the decision tool.
- ALEX also includes information about dental and vision, and EAP services and tax savings information that is especially helpful for the new CDHP/HSA

option.

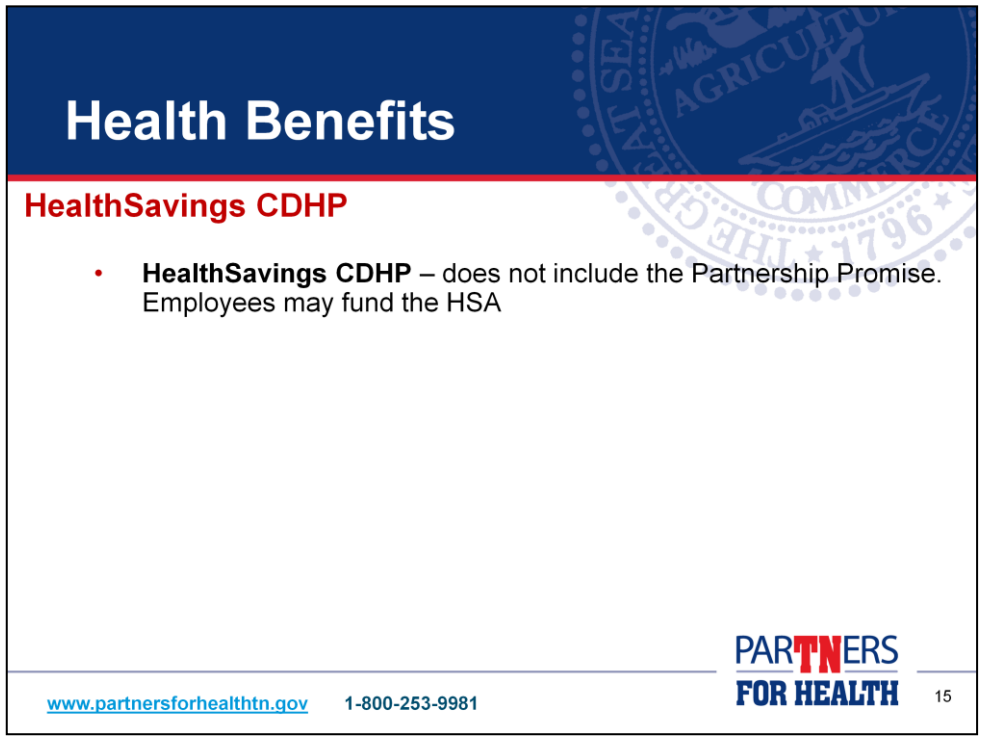


- Now, let's look at the health insurance options available to you through the State Group Insurance Program. When making your health insurance selection, there are three decisions to make:
  1. Insurance options
     - Partnership PPO (includes the Partnership Promise)
     - Standard PPO
     - Limited PPO
     - And the HealthSavings CDHP
  2. Insurance Carriers
     -- BlueCross BlueShield of Tennessee Network S
     -- Cigna LocalPlus Network
  3. Premium levels (tiers)

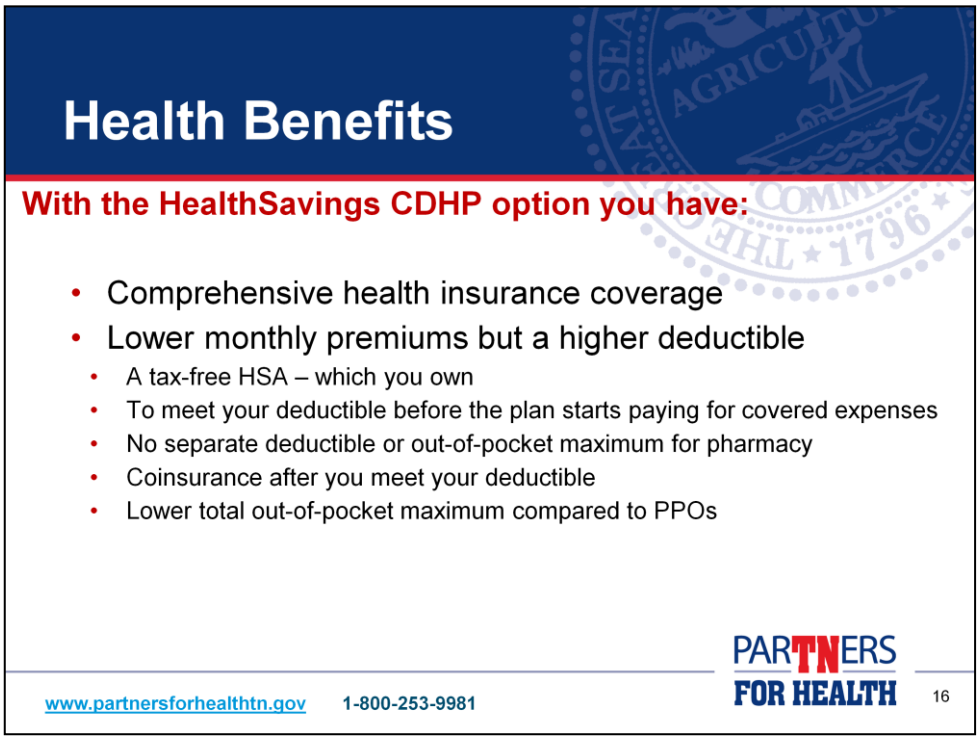
- We'll start with Preferred Provider Organizations, also known as PPOs
- With a PPO, you can visit any doctor or hospital you want. The PPO has a list of in-network doctors, hospitals and other providers that you are encouraged to use. Note that these in-network providers have agreed to take lower fees so you pay less for services. You will **ALWAYS** pay more for non-emergency services from out-of-network providers.
- We offer three PPOs, the Partnership PPO, Standard PPO and Limited PPO:
  - Same services and treatments, but you'll pay less in copays and coinsurance with the Partnership PPO.
  - You'll pay your deductible first before coinsurance applies for some services.
  - A separate out-of-pocket maximum for medical and pharmacy.
  - You'll pay for prescriptions with copays.
  - Once you reach your out-of-pocket maximum, the plan pays 100% for in-network services.



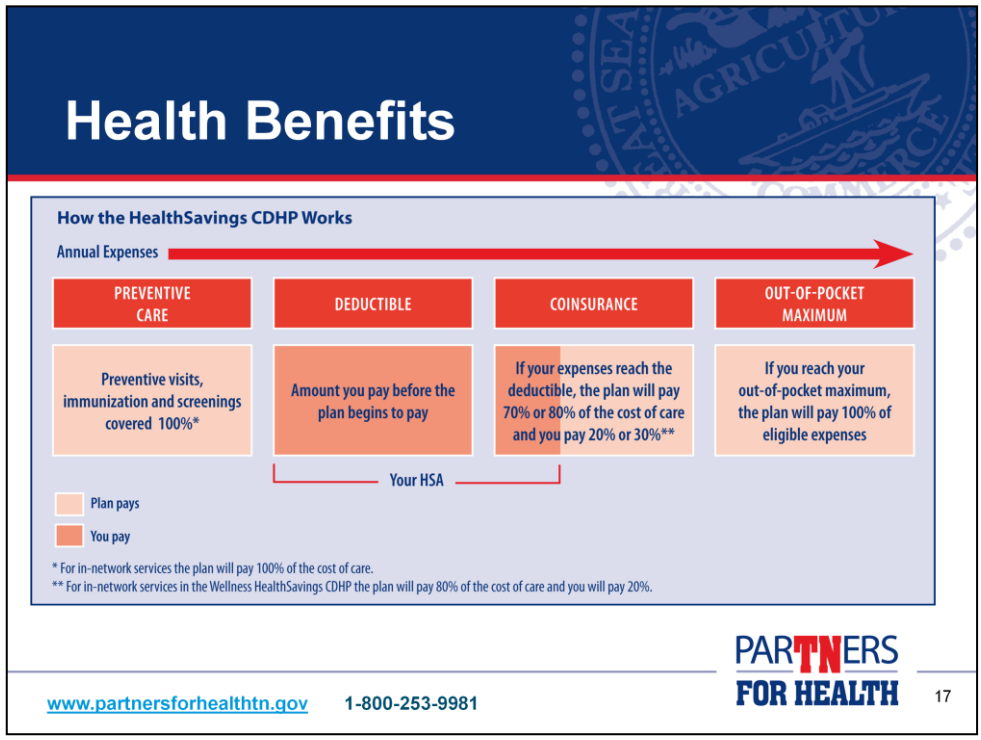
- The Standard and Limited PPOs offer the same services as the Partnership PPO. With the Standard PPO, you will pay **more** for monthly premiums, annual deductibles, copays, medical care co-insurance and out-of-pocket maximums. With the Limited PPO, you will pay **less** for monthly premiums but have higher out-of-pocket costs.
- Members enrolled in the Standard or Limited PPOs are not required to fulfill the Partnership Promise, but do have access to the ParTNers for Health Wellness Program at no additional cost.



- The State also offers a Consumer Driven Health Plan or a CDHP plan. You may also hear it sometimes called a High Deductible Health Plan or HDHP.
- The HealthSavings CDHP provide comprehensive health coverage while giving members a way to use and save pre-tax funds for qualified medical expenses.
- It includes a Health Savings Account (HSA) which can be used to pay for qualified medical, behavioral health, dental and vision expenses.
- The HealthSavings CDHP – does not include the Partnership Promise and the state will not put funds into your account. You can choose to fund your HSA on your own, and the money will still be tax free if used for qualified medical expenses.

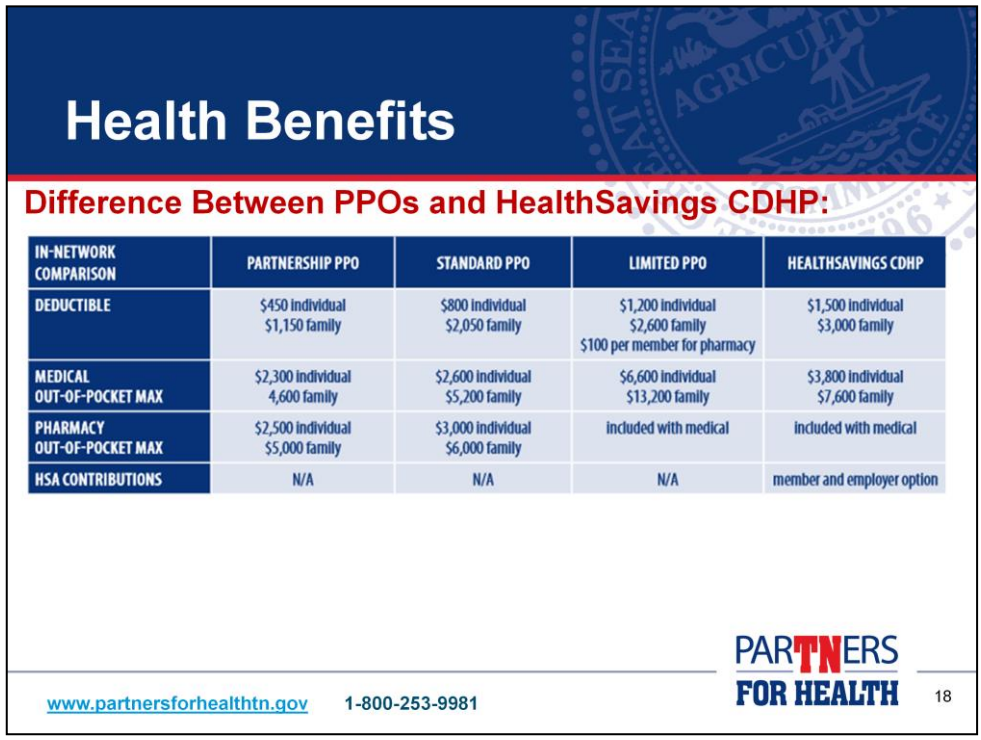


- **With the HealthSavings CDHP option you have:**
  - A lower monthly premium but a higher deductible.
  - A tax-free HSA – which you own and can use for qualified medical, dental and vision expenses, even if you leave your job or change health insurance plans.
  - To meet your deductible before the plan starts paying for covered expenses. But you can use the money in your HSA to pay for qualified medical expenses, including your deductible.
  - No separate deductible or out-of-pocket maximum for pharmacy.
  - Coinsurance **instead of copays** after you meet your deductible, until you reach your out-of-pocket maximum.
  - A lower total out-of-pocket maximum compared to the PPO's separate out-of-pocket maximums for pharmacy and medical/behavioral health.



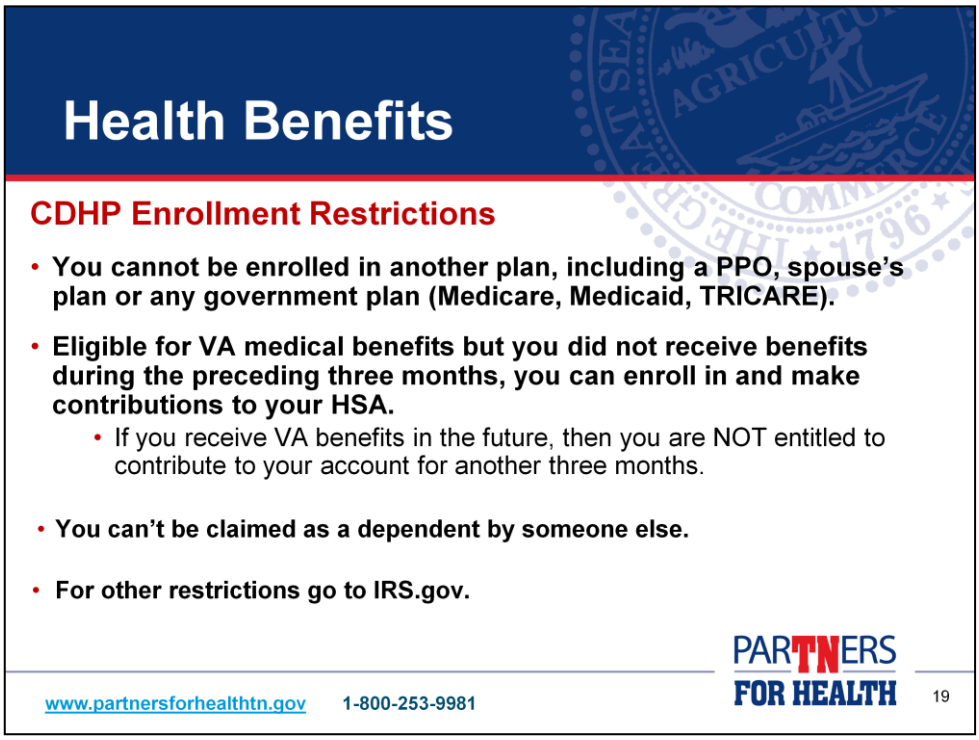
Here is a chart that shows how the HealthSavings CDHP works:

- Preventive care is covered in-network at 100%.
- You pay for health care expenses based on discounted network rates up to the deductible amount.
- When the deductible is met, you pay coinsurance for medical services at either 20% or 30%.
- For pharmacy – maintenance drugs are paid at 20% for the HealthSavings CDHP.
- When the out-of-pocket maximum is met, the plan pays 100% for eligible in-network expenses.



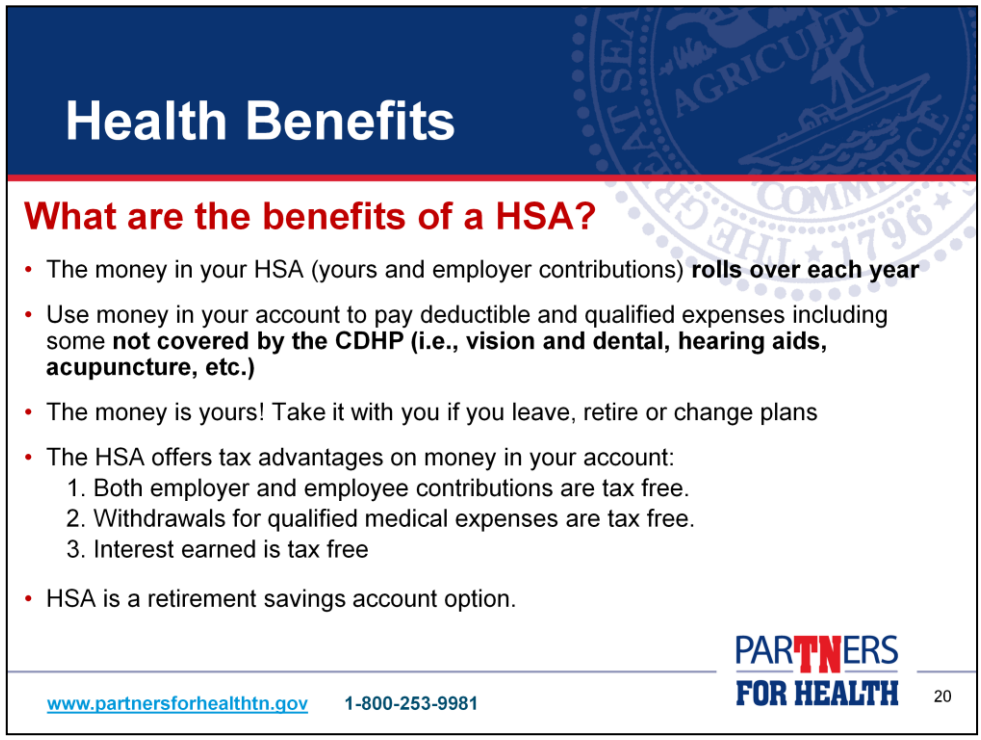
Here is a chart that highlights some of the differences between the PPOs and the HealthSavings CDHP:

- The HealthSavings CDHP deductible is higher than the PPOs.
- The pharmacy out-of-pocket maximum is included with medical. There is no separate pharmacy out-of-pocket with the CDHP.
- The HSA is only available with the CDHP plan.



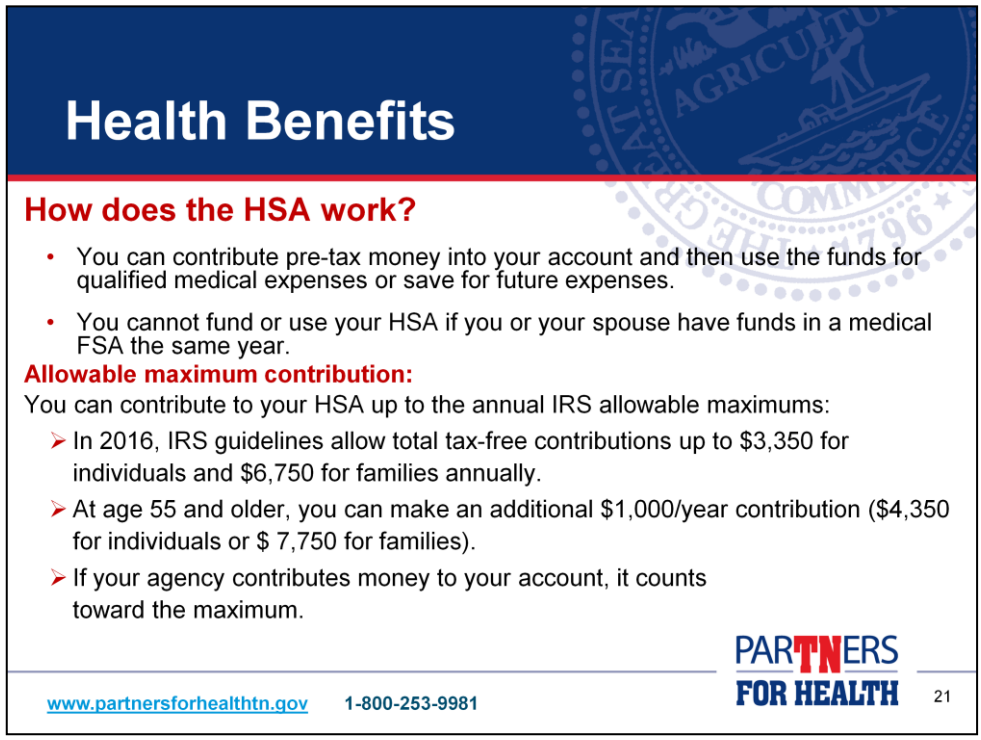
CDHP Enrollment Restrictions

- You cannot have a CDHP with a HSA and be enrolled in another plan, including a PPO, your spouse's plan or any government plan including Medicare A and/or B, Medicaid, TRICARE.
    - If you retire mid-year and enroll in Medicare, you cannot contribute to your HSA. You can use the funds though to pay for qualified medical expenses.
    - NOTE: Your covered spouse or dependents may be able to have other coverage and coverage with your plan. Check IRS guidelines.
- If you are eligible for VA medical benefits and did not receive benefits during the preceding three months, you can enroll in and make contributions to your HSA.
    - If you receive VA benefits in the future, then you are NOT entitled to contribute to your HSA for another three months.
- You cannot be claimed as a dependent by someone else.
- For other restrictions go to IRS.gov



What are the benefits of an HSA?

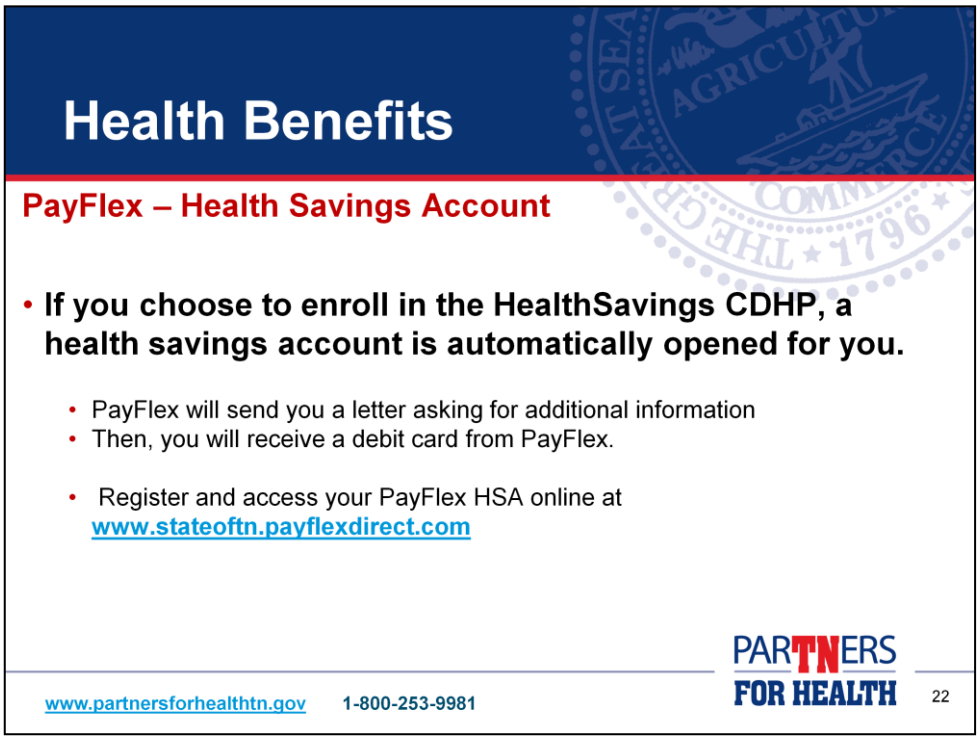
- The money you save in the HSA (both yours and any employer contributions) rolls over each year.
- You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses even if not covered by insurance like hearing aids, contact lens supplies and acupuncture with a great tax advantage.
- The money is yours! You don't lose it at the end of the year. You take it with you if you leave or retire.
- The HSA offers tax advantages:
    1. Both employer and employee contributions are tax free.
    2. Withdrawals for qualified medical expenses are tax free.
    3. Interest earned is tax free.
- It also serves as another retirement savings account option. Money in your account can be used tax free for health expenses even after you retire. And, when you turn 65, it can be used for non-medical expenses. But non-medical expenses will be taxed.



- You can contribute pre-tax money to your HSA through payroll deduction to cover your qualified medical expenses, including your deductible.
- You can also make post-tax contributions and claim it on your taxes.
- You cannot fund or use your HSA if you or your spouse (even if he or she is not covered on your plan) have money in a medical FSA the same calendar year.

➢ **You can contribute up to the IRS allowable maximums:**

- **In 2016, IRS guidelines allow total tax-free contributions up to $3,350 for individuals and $6,750 for families annually.**
- **At age 55 and older, you can make an additional $1,000/year contribution ($4,350 for individuals or $7,750 for families)**
- **If your agency contributes money to your account, it counts toward the contribution maximum.**



- PayFlex will ask you for additional information.
- PayFlex, the state's HSA vendor, will send you a debit card.
- You will register and access your PayFlex HSA online at www.stateoftn.payflexdirect.com.
- You may request additional cards from PayFlex.

- **The PayFlex Card** is a convenient way to pay for eligible expenses automatically, as long as funds are available. Keep your receipts for audit purposes.

- Or, you can pay for your eligible medical expenses with cash, check or personal credit card and pay yourself back from your HSA by transferring funds online to your bank account.

- Use PayFlex's online feature to pay your provider directly from your account.

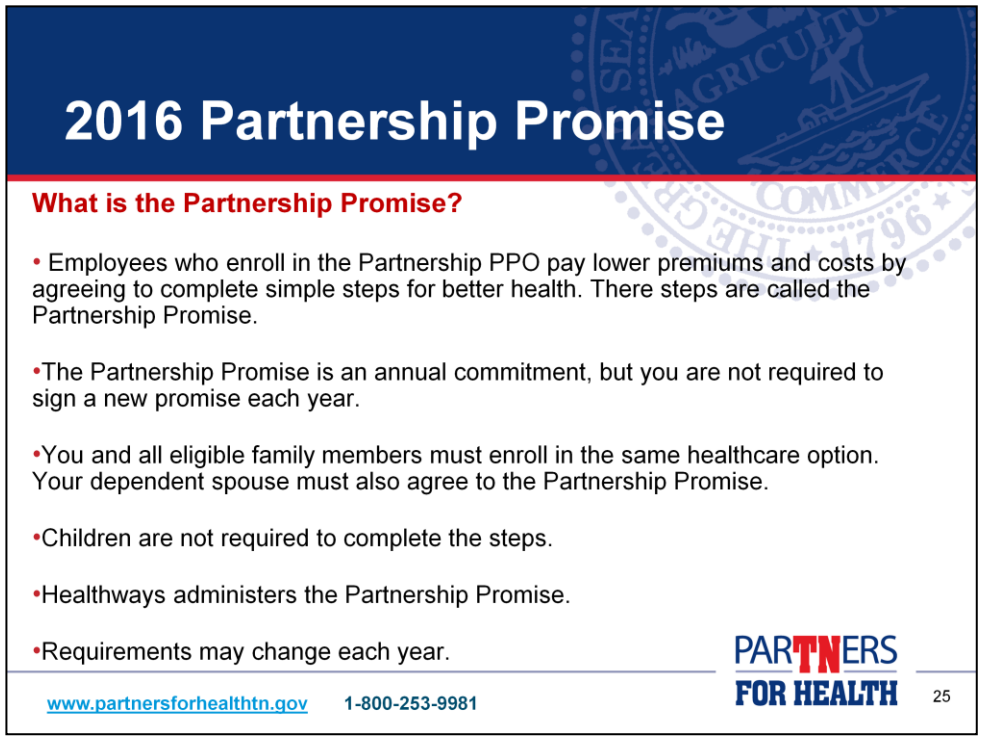
- **You can also contribute post-tax dollars** from your checking or savings account online and file for the deduction on your tax return.

The PayFlex free mobile app

- Makes it easy for you to manage your account online 24/7
- Available for iPhone and iPad mobile digital devices, Android and BlackBerry
- Can upload photos of your receipts of qualified expenses for tax purposes

- **Earn interest and invest your money**
  - Earn interest each month on the money in your HSA
  - When your account balance reaches $1,000 - you can invest the funds over this amount online

- **Account fees:** The state will pay for your HSA monthly maintenance fee as long as you are enrolled in a HealthSavings CDHP. You are responsible for standard banking fees like non-sufficient funds, stop payments, overdrafts and investment fees.
  - If you leave your job, retire or choose a PPO option in the future, you will be responsible for paying HSA maintenance fees.



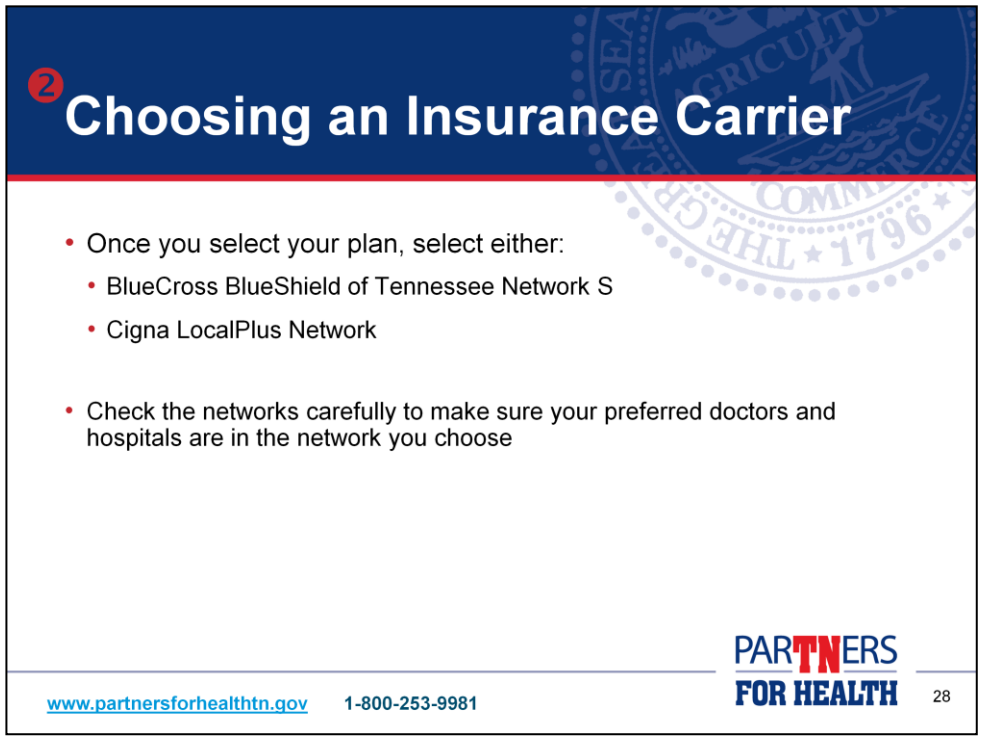
- If you enroll in the Partnership PPO, you pay lower costs by agreeing to complete simple steps for better health. These steps are called the Partnership Promise.
- The Partnership Promise is an annual commitment.
- You agree to fulfill the Partnership Promise each year you are enrolled in the Partnership PPO. You will not be required to sign a new promise each year.
- You and all eligible family members must enroll in the same healthcare option. Your dependent spouse must also agree to the Partnership Promise.
- Children are not required to complete the steps.
- Healthways administers the Partnership Promise.
- Requirements may change each year.

➢Goal of the Partnership Promise: To help you get and stay healthy.

➢ Poor health costs all of us.

➢But we can reduce healthcare costs with personal choices. Most members want to lose weight, eat healthy, increase exercise and quit tobacco. The Partnership Promise provides tools and resources to help members get and stay healthy and support those with chronic conditions.

- 2016 new members and their covered spouses must:
  - Complete the online Well-Being Assessment (WBA)
  - Get a biometric health screening from your physician.
- New employees who enroll in the Partnership PPO must complete the steps within 120 days from the day your coverage begins. If you fail to do so, you and your dependents will be transferred to a different plan the following year.
- **Note:** Employees with coverage effective dates of September 1 – December 1 DO NOT have to complete the Partnership Promise requirements within 120 days.
- **If you think you might be unable to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 1-888-741-3390, and they will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.**



- The next step is to choose between two carriers
  - BlueCross BlueShield of Tennessee, which offers Network S.
  - And Cigna, which offers the LocalPlus Network.
- You may choose between these two carriers, regardless of health option you select.
- Check the networks carefully for your preferred doctor or hospital when making your selection.
- Provider directories are available on the ParTNers for Health website (**partnersforhealthtn.gov**), by calling the carrier or from your ABC.
  - The online directories are found on the carrier's website and are always the most current version of the provider directories.

- Once you have selected your health option and carrier, you will need to choose your premium level. The amount you pay in premiums depends on the option you choose and the number of people you cover under the plan. There are four premium levels available: Employee Only, Employee + Child or Children, Employee + Spouse and Employee + Spouse + Child or Children.
- For most people, choosing a premium level is easy. The level depends on the eligible dependents you want to cover on your health plan.
  - Just remember, if you're enrolling as a family, all of you must be enrolled in the same state group health insurance option with the same insurance carrier.

Premiums: Local Government (Level 1)

Employee Share of Monthly Premiums

Premium Level	Partnership PPO	Standard PPO	Limited PPO	HealthSavings CDHP
Employee Only	**$611.55**	**$636.55**	**$391.61**	**$366.61**
Employee + Child(ren)	**$947.90**	**$972.90**	**$606.99**	**$568.24**
Employee + Spouse	**$1314.81**	**$1364.81**	**$841.96**	**$788.21**
Employee + Spouse + Child(ren)	**$1651.18**	**$1701.18**	**$1057.35**	**$989.85**

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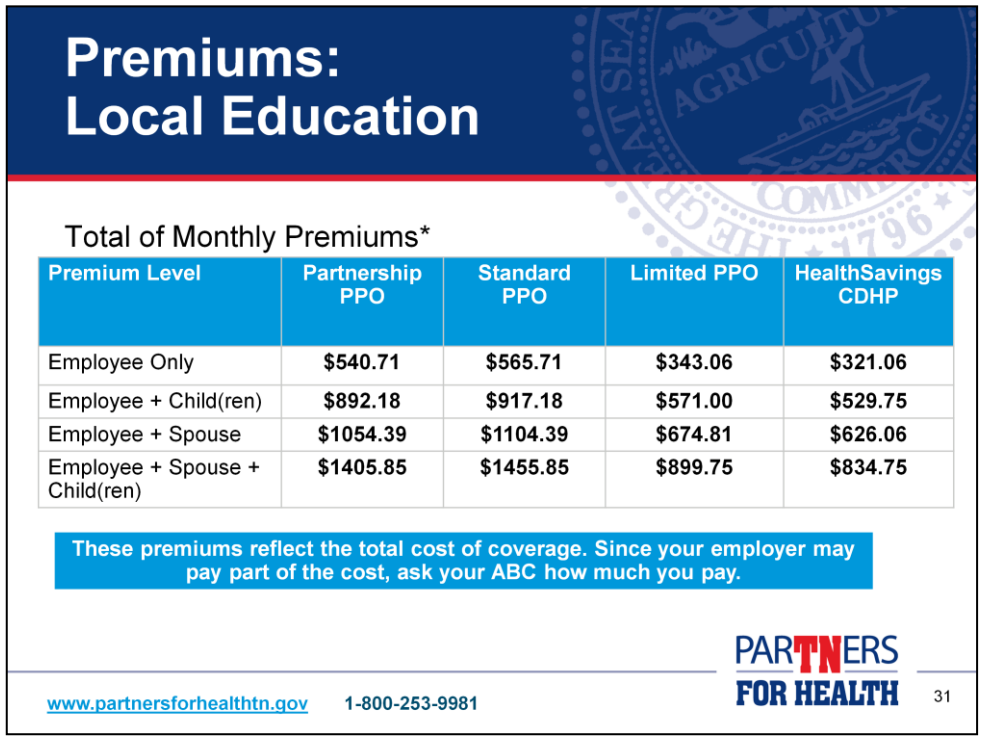
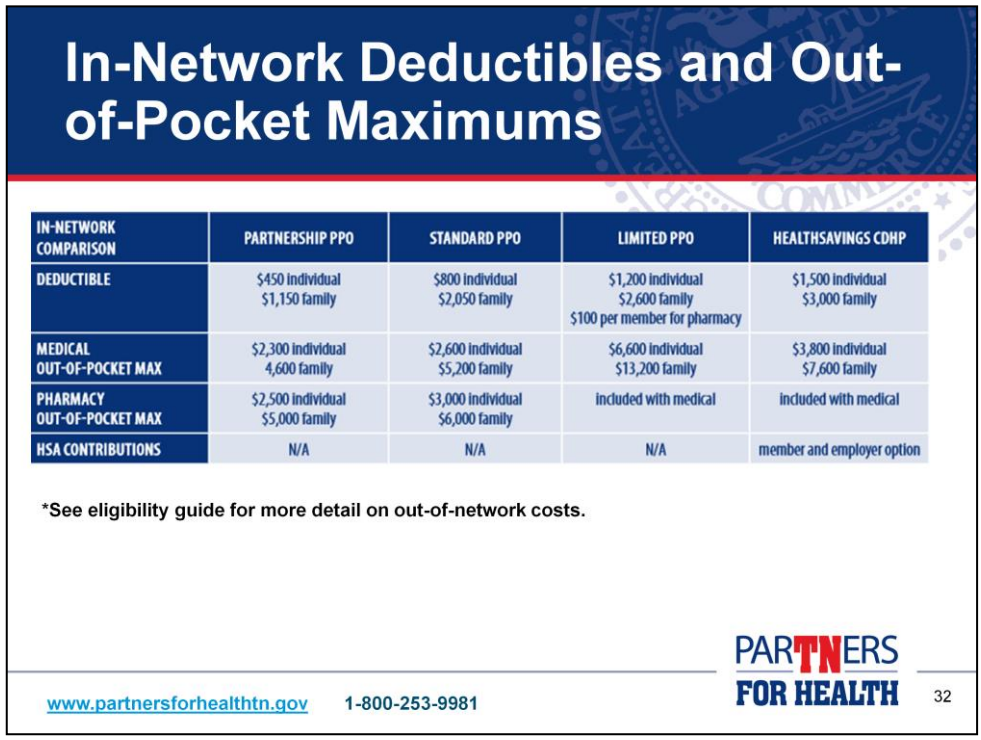
- Partnership PPO members receive lower premiums by agreeing to the Partnership Promise.
- A complete chart for all coverage tiers is available in the Eligibility & Enrollment Guide and on the ParTNers for Health website.

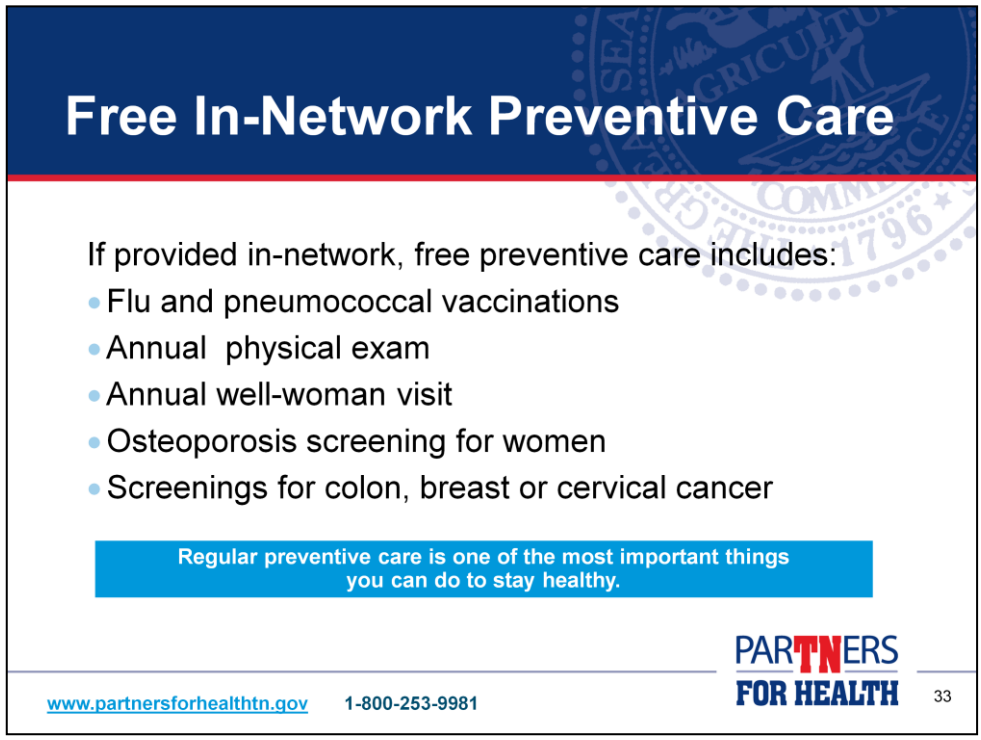


- Here are the total monthly premiums for Local Education Plan employees. The State contributes a portion of the premium cost for both instructional and non-instructional employees. The amount contributed by the employer varies, and employees pay the applicable balance. Please see your Agency Benefits Coordinator for your monthly deduction.
- A detailed premium chart is included in your Eligibility and Enrollment Guide and is also posted on the ParTNers for Health website.

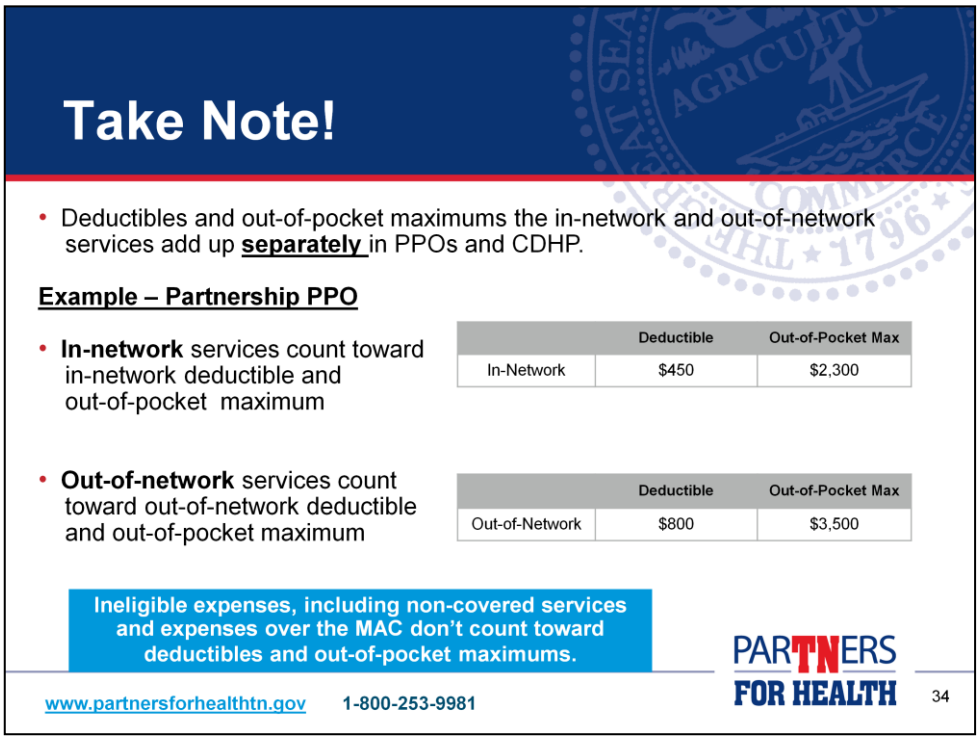


Here is an overview of the deductibles and out-of-pocket costs under each plan based on in-network services:

- The HealthSavings CDHP deductible is higher than the Partnership, Standard and Limited PPOs.
- There is no separate pharmacy out-of-pocket with the CDHP.
- The HSA is only available with the CDHP plan.
- Please check the Eligibility and Enrollment guide for more detail and for out-of-network cost deductibles and out-of-pocket maximums.



- Regular preventive care is one of the most important things you can do to stay healthy, so we want to take a minute to highlight the free preventive care available to you on all state health plan options. Free preventive services if received by an in-network provider, include
  - Flu and pneumococcal vaccinations
  - Annual physical exam
  - Annual well-woman visit
  - Osteoporosis screening for women
  - Screenings for colon, breast or cervical cancer, and more
- For some procedures, different medical criteria may apply based on the carrier you select.



- Deductibles and out-of-pocket maximums for in-network and out-of-network services add up separately. For the purpose of this example, we are looking at costs for someone with single coverage in the Partnership PPO.
- If you incur in-network expenses, that amount goes toward the in-network deductible of $450 and out-of-pocket maximum of $2,300. If you incur out-of-network expenses, that amount goes toward the out-of-network deductible of $800 and out-of-pocket maximum of $3,500. Also, eligible pharmacy expenses apply separately toward the pharmacy out-of-pocket maximum.
- Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.
- PPO copays do not count toward your deductible but do apply to out-of-pocket maximums, except for Partnership and Standard PPO in-network pharmacy costs which have a separate out-of-pocket maximum.

- Your health plan includes pharmacy benefits. It is automatically included when you enroll in health insurance.
- Pharmacy benefits are administered by CVS/Caremark, one of the largest pharmacy benefits managers in the country. Their network of more than 1,600 pharmacies in Tennessee includes many major chains and independent pharmacies. And more than 900 of them in Tennessee will fill 90-day prescriptions in the Retail 90 Network.
- The State's prescription drug coverage provides free tobacco quit aids to members who want to stop using tobacco products.
- You can refer to the Eligibility and Enrollment Guide or the ParTNers for Health website for more information about pharmacy benefits.

Prescription Drug Copays

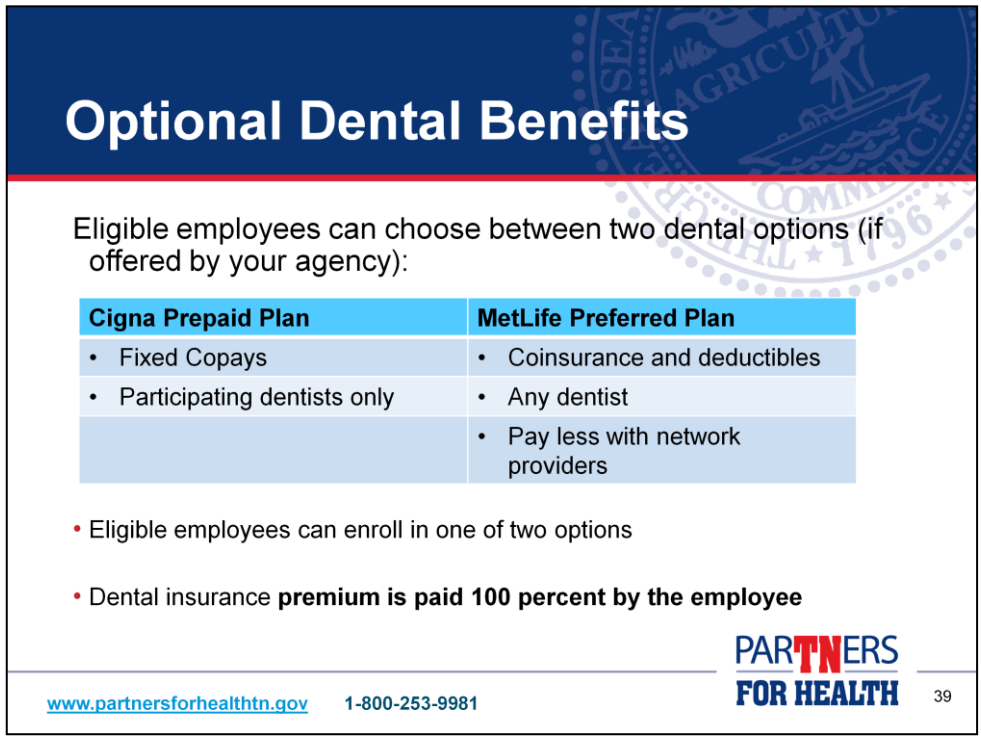
	Partnership PPO		Standard PPO		Limited PPO		HealthSavings CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
30-Day Supply (only from pharmacies in the 30-day network)	$5 copay generic $35 copay preferred brand $85 copay non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay for generic $45 copay for preferred brand $95 copay for non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay generic $55 copay preferred brand $105 copay non-preferred	Copay plus amount exceeding MAC	30% coinsurance	50% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic $65 copay preferred brand $165 copay non-preferred brand	N/A – no network	$20 copay for generic $85 copay for preferred brand $185 copay for non-preferred brand	N/A – no network	$20 copay generic $105 copay preferred brand $205 copay non-preferred	N/A – no network	30% coinsurance	N/A – no network
90-Day Supply (certain maintenance medications from 90-day pharmacy or mail order)	$5 copay generic $30 copay preferred brand $160 copay non-preferred brand	N/A – no network	$10 copay generic $40 copay preferred brand $180 copay non-preferred	N/A – no network	$10 copay generic $50 copay preferred $200 copay non-preferred	N/A – no network	20% coinsurance without first having to meet deductible	N/A – no network

- While the coverage for prescription drugs is the same for the PPOs, the copays will be less expensive in the Partnership PPO.
- With the CDHP you must pay the full negotiated cost for drugs up to the deductible. Then, your coinsurance kicks in.
- You will also save money by using the 90-day network to receive your medications through mail order or at a participating “mail at retail” pharmacy. **Please note**: Specialty medications have a 30-day supply limit and must be filled at a CVS/Caremark specialty network pharmacy.
- You can see from the chart that copays and co-insurance are lower for certain maintenance medications, when you use the mail order benefit or a 90-day network retail pharmacy. These specific maintenance medications include statins, antihypertensives, meds for asthma, COPD, depression, coronary artery disease, congestive heart failure and oral diabetic medications, insulins and supplies. Please note that diabetic supplies include needles, test trips and lancets only.

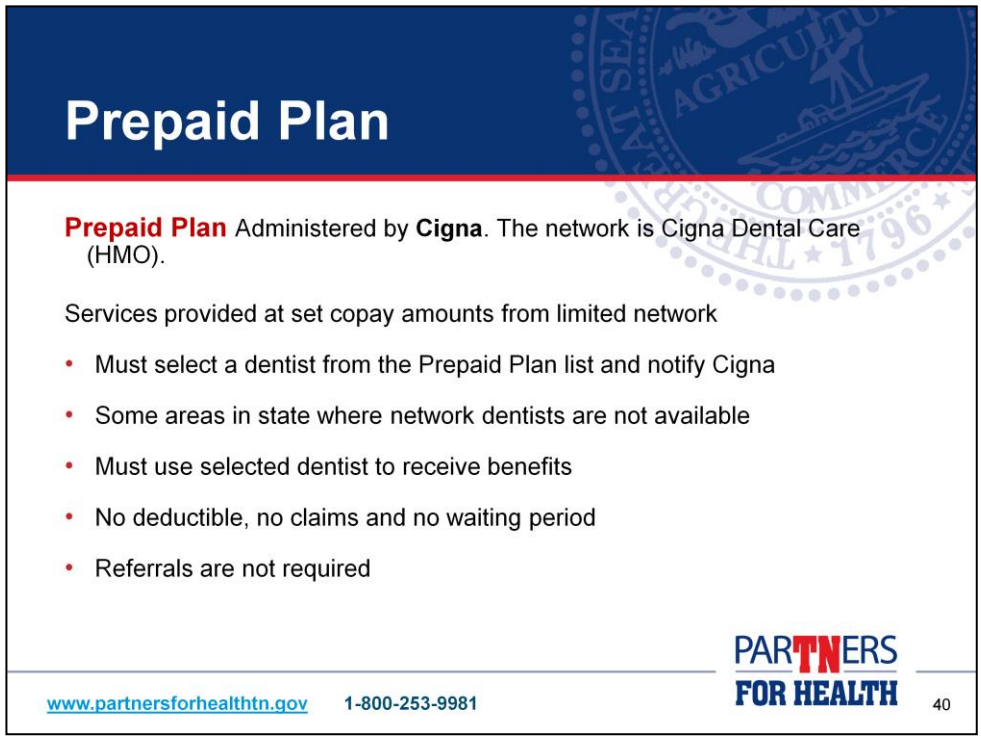
- **Employee Assistance Program (EAP):**
  - The Employee Assistance Program, or EAP, is offered to all employees and eligible dependents who are on the health plan.
  - The Employee Assistance Program (EAP) helps you and your family with both workplace and personal issues.
  - Services are free, confidential and available to members 24/7.
  - You and your eligible dependents may get up to five, free counseling sessions per problem episode, per year.
  - Your EAP also offers work-life services, financial and legal services, assistance finding eldercare and dependent care services and much more.
- **Work/Life Resources include:**
  - Finding solutions to the challenges you may face throughout all life stages. Such as prenatal care, adoption, infant and child care, education resources, retirement planning, senior care and special needs services, and more.
- **Legal/Financial Consultations include:**
  - Talking with an attorney to discuss your legal concerns. You may choose to have a phone or in-person consultation with a local attorney. The initial session is free to you.
  - You can be connected with a financial expert for a telephone consultation. Additional sessions are offered at a discounted rate after your first free hour.

  - Call 1.855.437.3436, or visit www.HERE4TN.com.

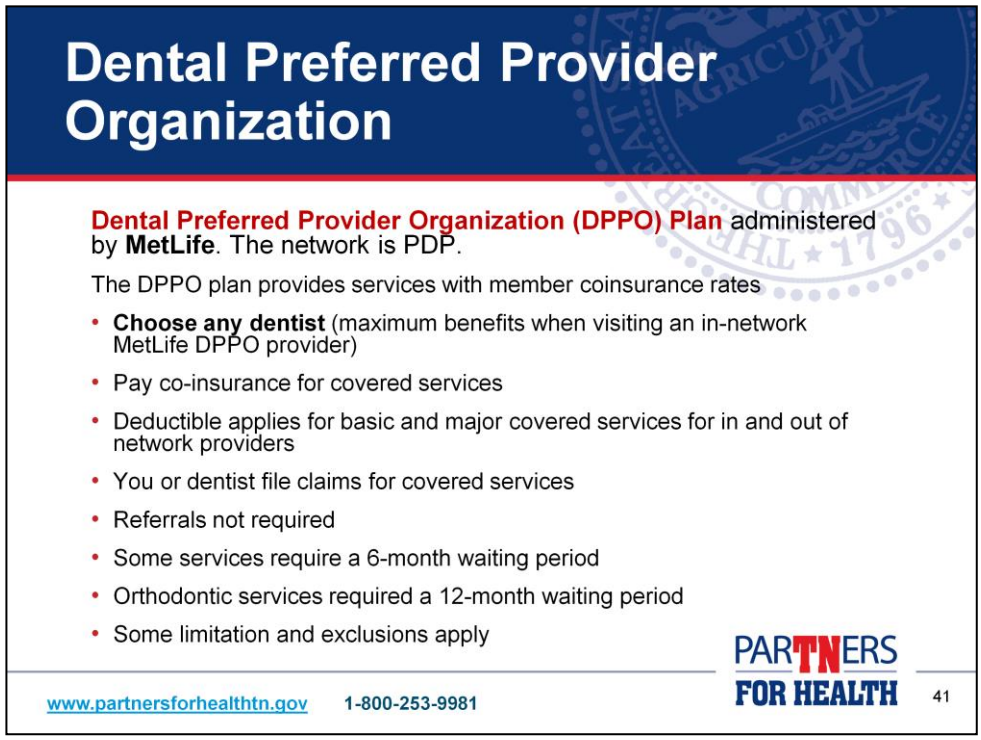
- Members and their dependents enrolled in health coverage have behavioral health and substance abuse treatment benefits through Magellan Health.
  - Call 1.855.HERE4TN (1.855.437.3486) or visit www.HERE4TN.com to access services or to speak with a trained professional for a referral day or night to access services:
    - Outpatient assessment and treatment
    - Inpatient assessment and treatment
    - Alternative care such as partial hospitalization, residential treatment and intensive outpatient treatment
    - Treatment follow-up and aftercare
- To receive maximum benefit coverage, participants must use a network provider. In some instances, such as inpatient care, preauthorization is required.
- Copays and co-insurances for these services are based on your PPO and CDHP selection. Prior authorization is required for some outpatient and all inpatient services.



- Now let's talk about dental benefits. **Whether or not you're eligible for certain benefits depends on where you work. Your ABC will be able to tell you if your agency participates in the State's dental plan.** If you're not eligible for coverage in the State's dental plans, you may skip to the "Additional Benefits" section.
- Now let's talk about dental benefits. You can choose between two dental plans – a Prepaid Plan and a Dental Preferred Provider Organization often called a DPPO.
- You do not have to be enrolled in health coverage to enroll in dental insurance.
- In the prepaid plan, you must select from a specific group of dentists.
- Under the DPPO plan, you may visit the dentist of your choice; however, members receive maximum savings when visiting a DPPO network provider.
- Both dental options have specific guidelines for benefits such as exams and major procedures, and have a four-tier premium structure just like health insurance. Be sure to check with the dental provider to make sure the dentist you want is in the network.
- Like health insurance, you pay premiums upfront for dental coverage regardless of whether or not you use any services. What you pay depends on the plan you choose. However, unlike health insurance where a portion of the premium is paid by the employer, the cost of dental insurance is paid 100 percent by the employee.

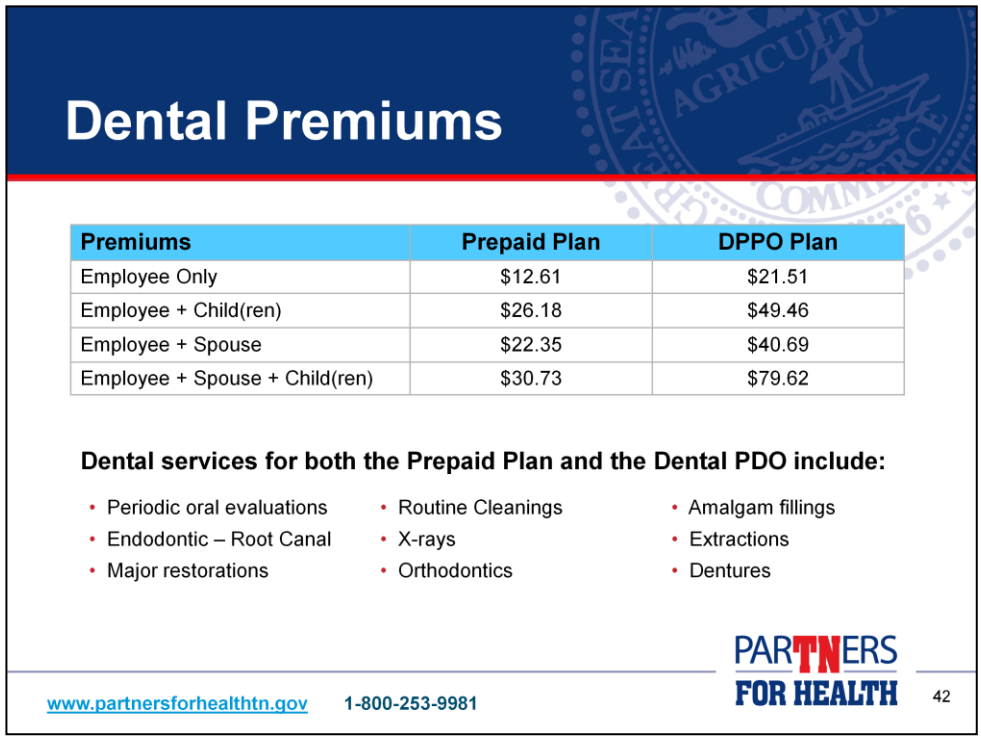


- The **Prepaid Plan** is administered by Cigna and provides services at predetermined copay amounts from a limited network of participating dentists and specialists. The network is Cigna Dental Care (HMO).
- **To receive benefits**, you must select a dentist from the Prepaid Plan list and notify Cigna of your selection.
- There are some areas in the state where the network dentists are not available and some may not accept new prepaid members. Review the provider directory carefully.
- You must use your selected dentist to receive benefits.
- This plan provides services at predetermined member copay amounts (reduced fees) for dental treatments.
- There are no deductibles to meet, no claims to file, no waiting periods for covered services, no annual dollar maximum and pre-existing conditions are covered.
- Referrals are not required.
- To find a dentist in Cigna's network, visit the dental section of the ParTNers for Health website or call the Cigna call center at the number listed on the inside cover of the Eligibility and Enrollment Guide.

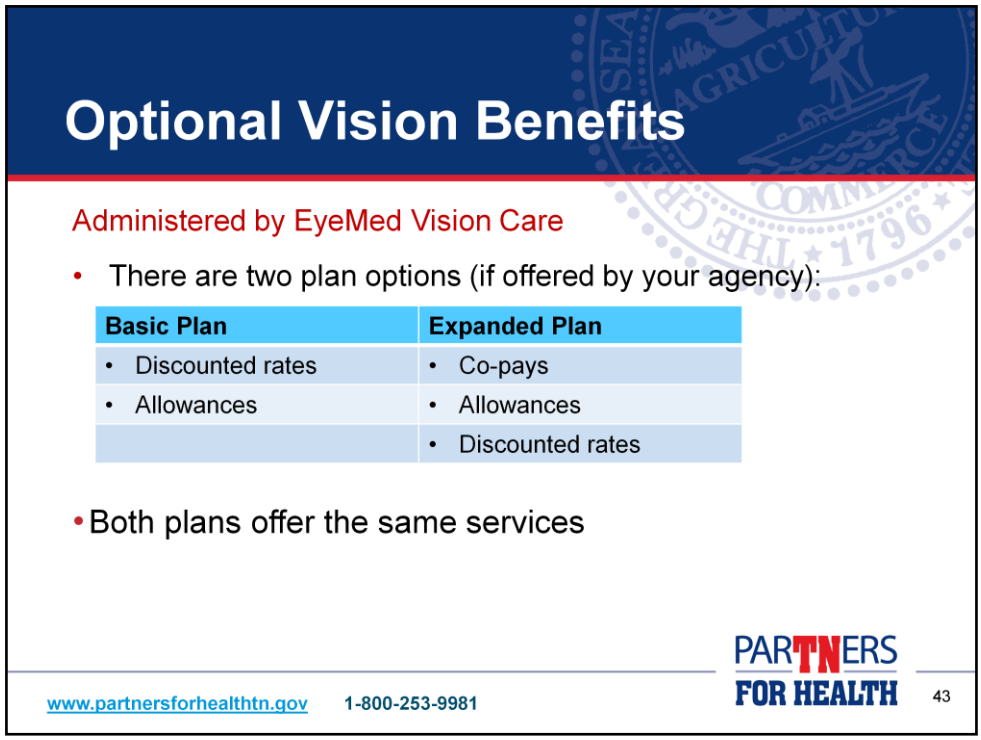


The DPPO plan is administered by **MetLife**. It provides services with member coinsurance rates.

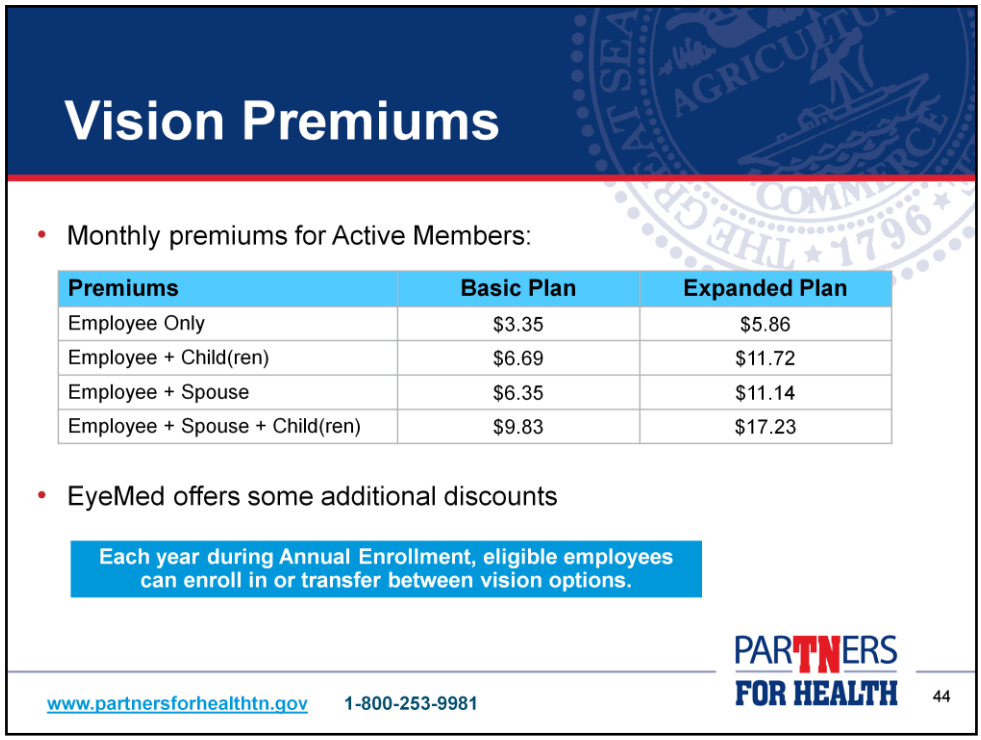
- You can choose any dentist but maximum benefits are available when visiting an in-network MetLife DPPO Provider. The network is PDP.
- You pay co-insurance for covered services.
- Deductible applies for basic and major covered services for in and out of network providers.
- You or your dentist will file claims for covered services.
- Referrals to specialists are not required.
- Some services such as crowns, dentures, implants, etc. require a 6-month waiting period before benefits begin.
- There are limitations and exclusions, for example, no benefit for cosmetic reasons.
- You can find a dentist in MetLife's network by visiting the dental section of the ParTNers for Health website or by calling the customer service center at the number listed on the inside cover of the Eligibility and Enrollment Guide.



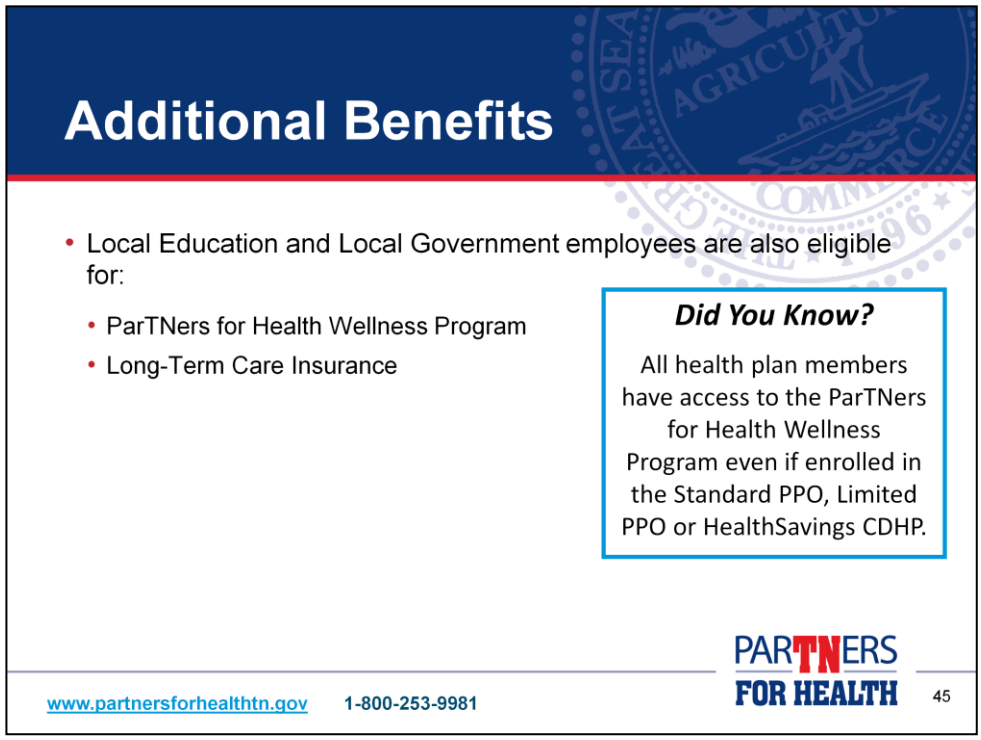
- Just like health insurance, there are four premium levels from which you can choose for either plan. The premium level you select will depend on the number of dependents you choose to cover.
- Dental services for both Cigna Prepaid Plan and MetLife DPPO plan include:
  - Periodic oral evaluations
  - Routine Cleanings
  - Amalgam fillings
  - Endodontics – Root Canal
  - X-rays
  - Extractions
  - Major restorations
  - Orthodontics
  - Dentures



- The optional vision plan is administered by EyeMed Vision Care.
- **Optional vision coverage is available to eligible employees and dependents, if your agency offers it. Check with your Agency Benefits Coordinator to see if you agency offers the State's vision plan.** You do not have to be enrolled in health coverage to enroll in vision insurance.
- The optional vision plan is administered by EyeMed Vision Care.
- **Choose from two plans:**
  - With the basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials.
  - The expanded plan provides services with a combination of copays, allowances and discounted rates.
- Both plans offer the same services including:
  - Annual routine eye exam (once every calendar year)
  - Frames (once every two calendar years)
  - Eyeglass lenses (once every calendar year) or contact lenses (once every calendar year)
  - Discount on Lasik/Refractive surgery
- In-network and out-of-network benefits are available. Go to **partnersforhealthtn.gov** for a list of limitations and exclusions.
- You will receive the maximum benefit when visiting a provider in EyeMed's Select Network.



- This chart shows the premiums associated with each vision plan. There are four premium levels from which you can choose, and the premium level you select will depend on the number of dependents you choose to cover.
- Members are responsible for the full premium.
- **EyeMed offers some additional discounts**:
  - 40 percent off on additional pairs of eyeglasses at any network location, after the vision benefit has been used.
  - 15 percent off conventional contact lenses after the benefit has been used.
  - 20 percent off non-covered items such as lens cleaner, accessories and non-prescription sunglasses.
  - **Expanded plan only**: 25 percent to 50 percent savings on premium progressive lenses and anti-reflective lenses.
- If you do not enroll in the vision plan as a new employee, you can add coverage later during Annual Enrollment. Each fall during Annual Enrollment, eligible employees can enroll in or transfer between vision options.



- In addition to health benefits, you also have access to other benefits. These additional benefits include the ParTNers for Health Wellness Program and Long-Term Care Insurance.

ParTNers for Health Wellness Program

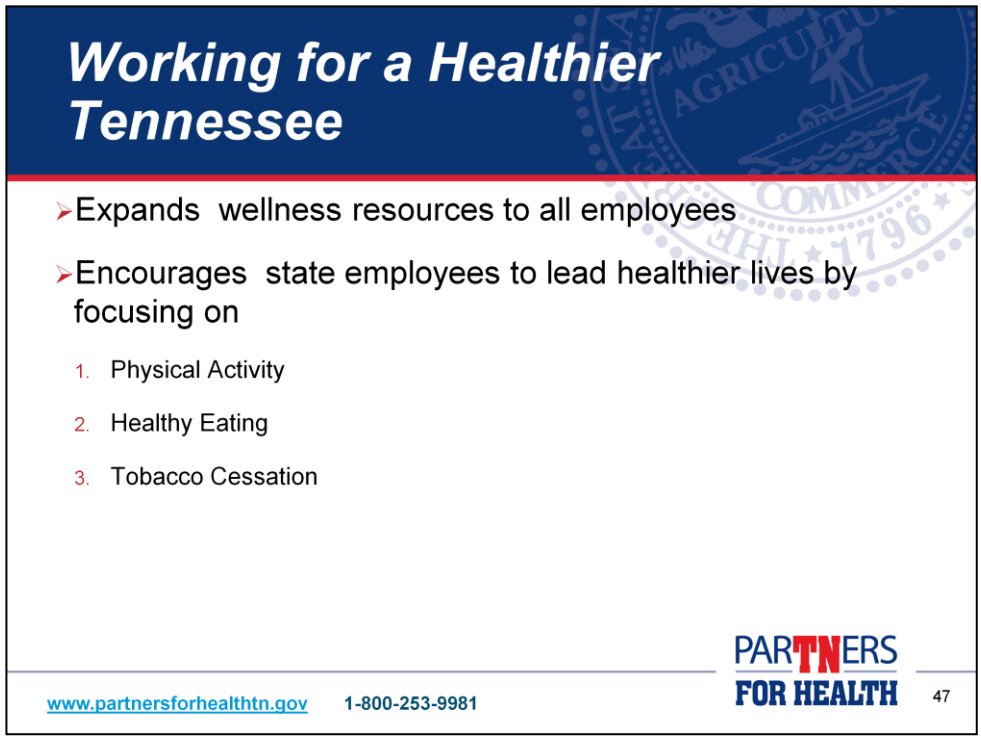
You don't have to be in the Partnership PPO to take charge of your health and feel your best. The ParTNers for Health Wellness Program is **FREE** to all health insurance plan members. Everybody can take small steps to improve their health.

The Wellness Resources include:

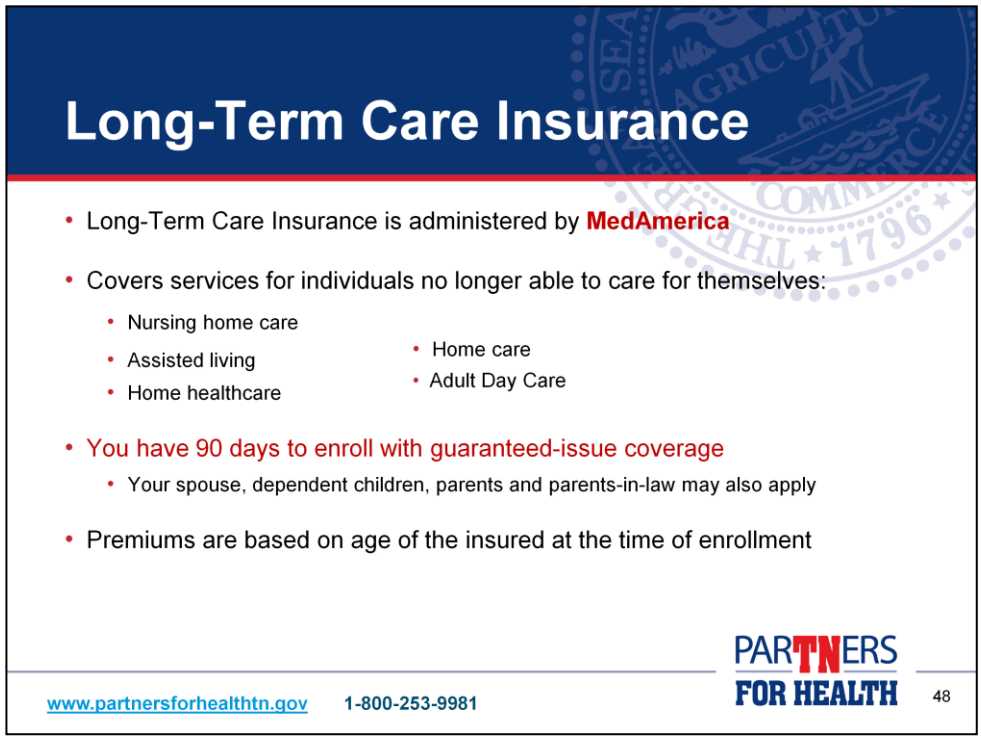
- **Coaching** offers professional support to create and meet goals to improve your health.
- **Well-Being Assessment** (WBA) is an online questionnaire to help you learn more about your health and identify any potential risk. New Partnership PPO members must complete the WBA within 120 days.
- **Nurse Advice Line** gives you medical information and support 24/7 at no cost to you. Call 888.741.3390 to reach the nurse line.
- **Quarterly Wellness Challenges** offer a fun way to help you develop a healthier lifestyle while providing group support.
- **Weight Watchers at Work discounts** and **Fitness Center discounts** offer affordable ways for members to improve their health.
- **Additional wellness and fitness discounts** are available through the EAP

program and our carriers **BCBST** and **Cigna**.

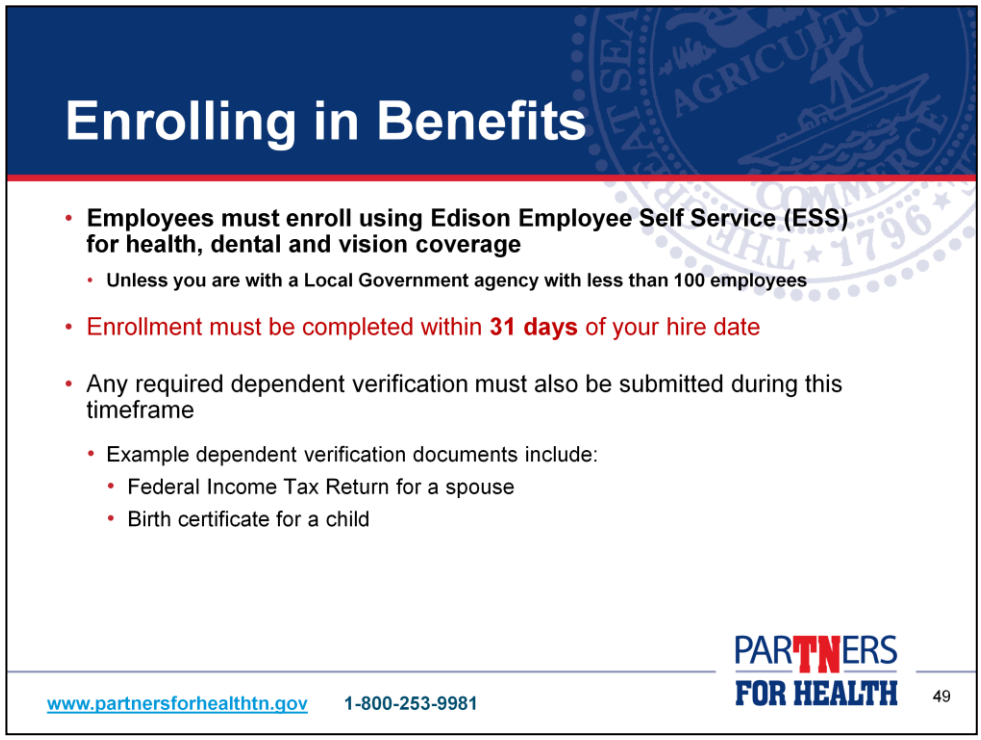
- To access any of these services offered by the wellness program, contact the ParTNers for Health Wellness Program go to the ParTNers for Health website or call **1-888-741-3390.**



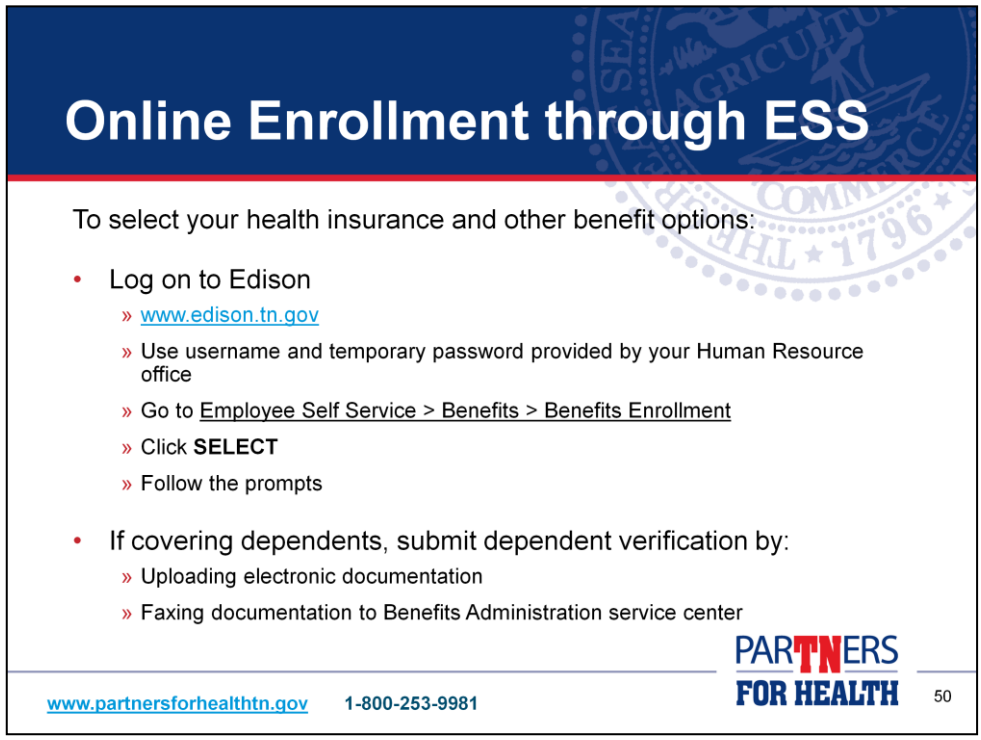
- The *Working for a Healthier Tennessee* initiative was implemented under the leadership of Governor Bill Haslam and is supported by the ParTNers for Health Wellness Program and the ParTNers Employee Assistance Program.
- It expands wellness resources to employees regardless of whether or not they are enrolled in health coverage.
- Its goal is to encourage and enable employees to lead happier, healthier lives. Most agency's have a Site Champion to help employees improve in three key areas: physical activity, healthy eating and tobacco cessation.



- Qualified employees, their eligible dependents (spouse and children ages 18 – 25), retirees, parents and parents-in-law are eligible to enroll in long-term care insurance through MedAmerica.
- It covers services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness or an accident may bring on this need.
- Services covered include nursing home care, assisted living, home healthcare, home care and adult day care.
- As a new employee, you have 90 days to enroll and have guaranteed-issue coverage. This means you will be allowed to enroll regardless of your health, age, gender or other factors that might predict your use of health services, such as a pre-existing condition.
  - You may still apply for coverage later, but will be subject to medical underwriting review. If they apply, your spouse, eligible dependent children (ages 18 through 26), parents and parents-in-law must answer questions about their health status and will be subject to medical underwriting review
- The premium for this optional program is the full responsibility of the member. Premiums are based on the age of the insured at the time of enrollment. So the younger you are when you apply, the lower your monthly premium will be. You may choose to have the monthly premium taken from your payroll check or may opt for a direct bill arrangement with the carrier for quarterly, semi-annual or annual premium payment.

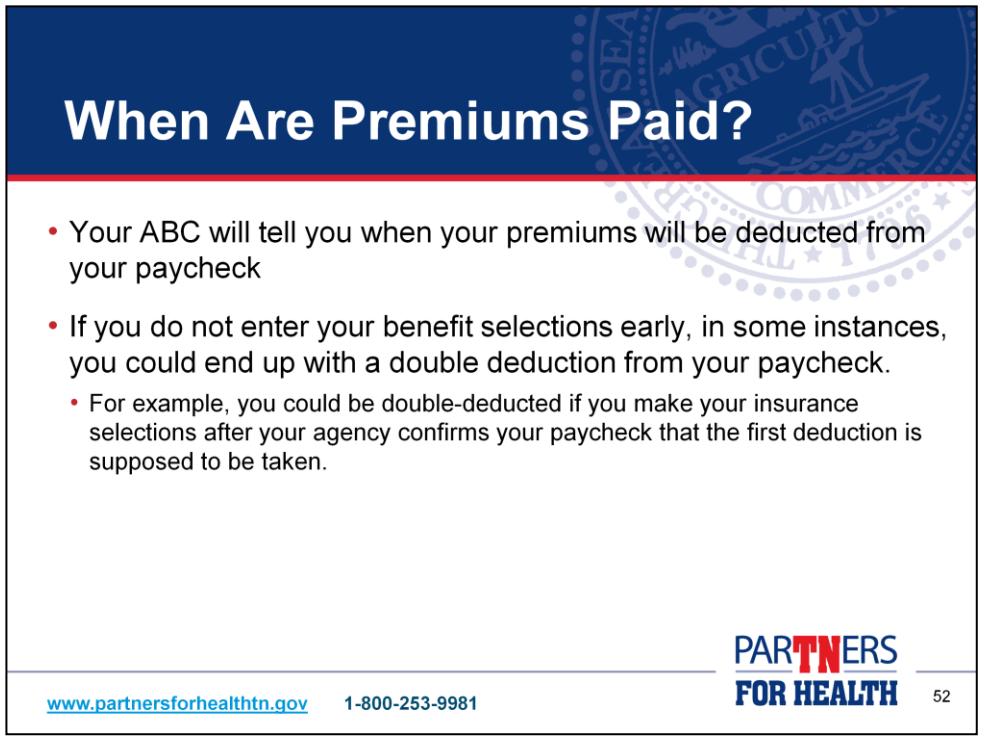


- If you choose to enroll in health, vision or dental benefits, there are two ways to enroll:
  - One option is to complete a paper form called the Enrollment Change Application. If you choose to use the paper application, you will return this form to your ABC once you have made your selections. Your ABC will sign the form and submit it to Benefits Administration to process.
  - A better option is to submit your benefit selections online using Edison Employee Self-Service or ESS for short. ESS allows you to make your selections electronically, which many employees find to be faster and easier than the paper form.
- Enrollment must be completed within 31 days of your hire date. If you want to cover your spouse or children, you will also need to provide documentation during this time to verify their relationship to you. Examples of dependent verification can include a marriage license and Federal Income Tax Return for a spouse or a birth certificate for a child. A complete list of required documentation for dependent verification can be found on the BA website (**www.tn.gov/finance/section/fa-benefits**) under the **Forms** tab in the **Health and Dental** box.
- Long-Term Care Insurance enrollment is available through the MedAmerica website or by completing a paper enrollment form.

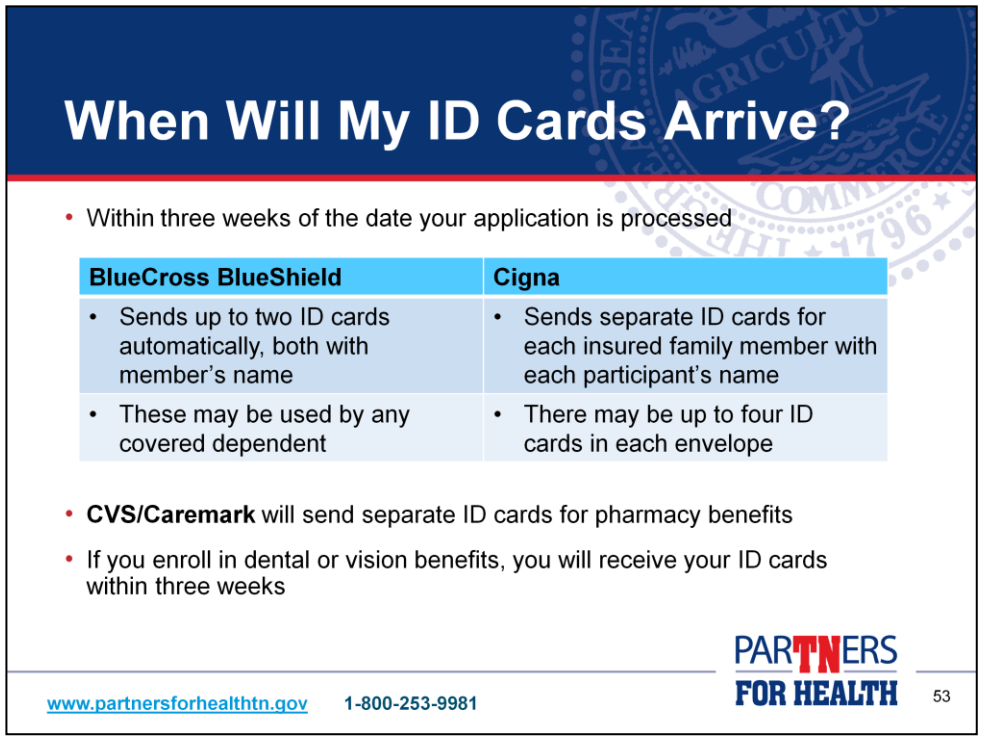


- Employees can enroll in health insurance and other benefit options online through Employee Self Service (ESS).
- Online enrollment is easy and convenient. Simply log in to Edison using the username and temporary password provided by your Human Resource office or ABC. Navigate to bottom left hand side of the main page and select "**Benefits Enrollment**". You will then click on the "**Select"** button to start enrollment. Follow the prompts to make your selections and the system will take you through the rest of the process.
- If you are covering dependents, you can submit your dependent verification by uploading copies of the appropriate documentation in Edison. Or, if you do not have electronic copies, you may also fax the required documentation to the Benefits Administration service center at 615-741-8196.

- Once you enroll, your health, vision and dental, will begin on the first day of the month.
- Your ABC can help if you have questions about when your coverage begins.

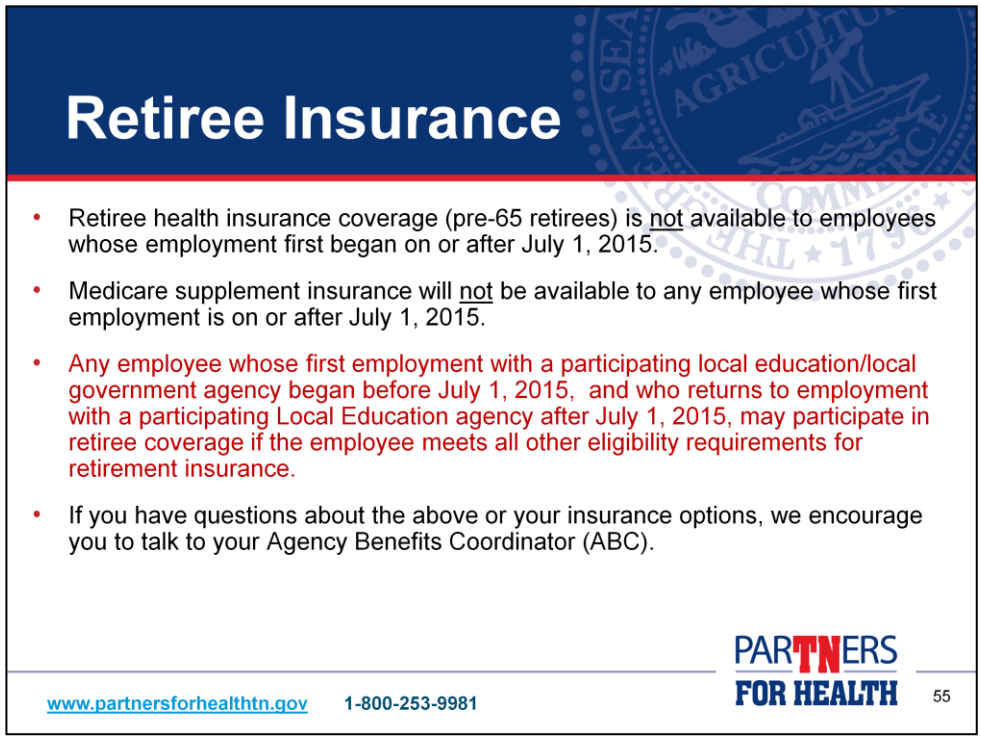


- Your ABC will tell you when your premiums will be deducted from your paycheck.
- We do recommend entering your benefit selections in ESS or submitting your enrollment forms to your ABC as soon as possible.
- If you do not enter your benefit selections early, in some instances, you could end up with a double deduction from your paycheck.
  - For example, you could be double-deducted if you make your insurance selections after your agency confirms your paycheck that the first deduction is supposed to be taken.



- Once your enrollment application has been processed, you will generally receive your new health insurance ID cards within three weeks.
- If you enrolled in health coverage with BlueCross BlueShield, you will receive up to two ID cards automatically. The member's name will be printed on all cards, but these cards may be used by any covered dependent.
- If you choose health coverage with Cigna, you will receive separate ID cards for each insured family member with the participant's name printed on each. Cigna will send up to four ID cards in each envelope and additional ID cards in a separate envelope.
- After you receive your initial cards, if you need additional ID cards, you can request them by contacting the carriers directly.
- In addition to your health insurance ID cards, you will also automatically receive separate pharmacy ID cards. If you are enrolled in family coverage, your ID cards may be sent in separate envelopes.
- If you enroll in dental or vision coverage, you will typically receive your ID cards within three weeks.

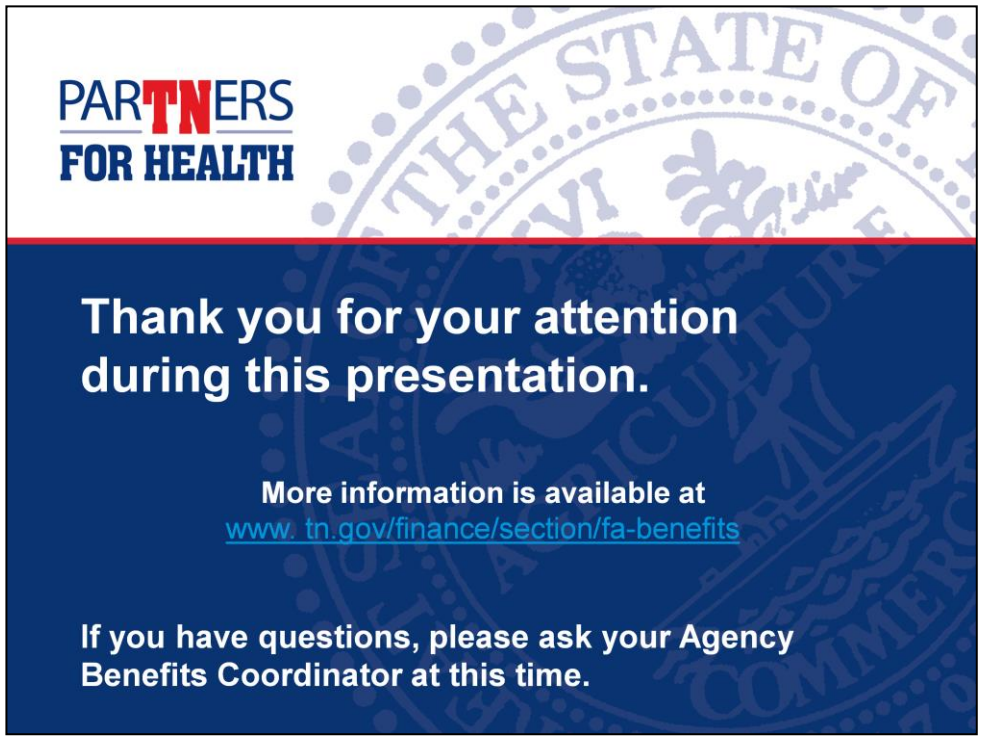
- All of our members' personal health information is strictly confidential. Your health privacy rights are protected through a federal law called HIPAA. It requires your personal health information not be shared without your consent so Benefits Administration can only discuss benefit information with the employee who is enrolling in coverage, also known as the head of contract or HOC.
- If you would like to grant Benefits Administration permission to speak to someone other than you about your benefits, please complete and submit an Authorization for Release of Protected Health Information form to Benefits Administration. This will allow your spouse or another individual of your choosing to receive your health information on your behalf. This form is available in the forms section of our website or from your ABC.
- Please note that your personal health information may be used or disclosed by and within each plan as well as the State Group Insurance Program third-party "business associates" or contractors as needed for your treatment, payment of benefits or other health care plan operations.



- A new law regarding retiree insurance was approved by the legislature in April of 2015.
- As of July 1, 2015, retiree health insurance coverage for pre-65 retirees will not be available to any employee whose employment with the state first began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
- Medicare supplement medical insurance will not be available to any employees whose first employment with the state began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
- If you have questions about the above or your insurance options, we encourage you to talk to your Agency Benefits Coordinator (ABC).

- BlueCross BlueShield, Cigna and CVS/caremark each offer member websites that allow you to view detailed information about your claims, print temporary ID cards and access other helpful member services. These member websites offer a convenient way to keep track of your health insurance benefit information. All you have to do is create an online account to get started.

- We have covered a lot of new information in this presentation, so it's important to know who to ask if you have questions or need more information at a later time. Your ABC will be your primary point of contact, and he or she will be able to answer many of your benefits-related questions or help point you in the right direction.
- If you have questions about a provider or insurance claim, contact your insurance carrier directly. You can find your carrier's number in the Eligibility and Enrollment Guide or by visiting their member website. Once you receive your ID card, you can also find the carrier's phone number listed on the back of your card.
- If you have specific questions regarding eligibility or enrollment in benefits, you may call the Benefits Administration service center at 1-800-253-9981.
- The ParTNers for Health and Benefits Administration websites are great resources as well, and include contact information for all of our benefits vendors.



- This concludes the new employee benefits orientation. To watch this presentation again, or to access the forms and other resources discussed during this presentation, visit the Benefits Administration New Employee Page. Go to www.tn.gov/finance/section/fa-benefits and click on the New Employee tab on the left side of your screen.
- Thank you for your attention during this presentation. If you have questions, please ask your Agency Benefits Coordinator at this time.